M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (126)

03694

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8

Hospital, institution, or street address where death occurred: Leland Memorial Hospital

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Wash., D.C. County:

City or town: District of Columbia (If outside city or town limits, write RURAL and give nearest town)

Street No. 1821 Jackson St. N.E. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Laura Pfeiffer Adams

3. (b) Social Security Number:

4. Sex: F

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: William Adams

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): July 27, 1872

8. AGE: Years 72 | Months 8 | Days — | If less than one day ... hrs. ... min.

9. Birthplace: Marietta, Ohio (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER 12. Name: ?

13. Birthplace: Germany ?

MOTHER 14. Maiden name: ?

15. Birthplace: Germany ?

16. Informant: Hospital records and

Address: Mrs. Keyser - 1821 Jackson St. N.E. D.C.

17. Burial — Date thereof 4-2-45 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: C. Hill Cemetery

Location: Suitland, Md.

18. Funeral director: W.W. Chambers Co.

Address: Riverdale, Md.

19 April 1 1945 (Date rec'd by registrar) Jas Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27, 1945, at 5:15 p. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1938, to Mar 27 1945

and that I last saw her alive on Mar 27 1945

Cause	Duration
Immediate cause of death: Uremia	3 days
Due to: Multiple liver abscess	3 days
Due to: Post operative Cholecystectomy for	5 days
Other conditions: Chronic Cholecystitis and Cholelithiasis (Include pregnancy within 3 months of death)	

Major findings of operations: Thick contracted Gall bladder with stones. Date of op. Mar 22 1945

Autopsy results: See Diagnosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: L. W. Malin M.D. (M. D. or other)

Address: Riverdale, Md. Date signed 3-30-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48)

CERTIFICATE OF DEATH

03695

Reg. Dist. No. 245

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County PRINCE GEORGES
City or town RIVERDALE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 39 days
Hospital, institution, or street address where death occurred:
LELAND MEMORIAL Hospital
How long in hospital or institution? 2-13-45 to 3-24-45

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of motber)
State M.D. County MONTGOMERY
City or town AVENEL (RURAL) SILVER SPRING
(If outside city or town limits, write RURAL and give nearest town)
Street No. MT. PISGAH ROAD
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME ADDA WALTER BEAN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	married

6.(b) Name of husband or wife TARLETON SMITH BEAN
6.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) NOV. 15, 1891

8. AGE: Years	Months	Days	If less than one day
53	4	9	..... hrs. ..... min.

9. Birthplace FOREST County, PENNA (Town, county, and state)
10. Usual occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name GEORGE B. WALTER
13. Birthplace PENNA.

MOTHER
14. Maiden name unknown
15. Birthplace Pa

16. Informant Tarleton S. Bean
Address Avenel, S. Spring, md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-27-45 (month) (day) (year)
Cemetery or crematory FORT LINCOLN Cemetery
Location Wash DC.
18. Funeral director W.W. Chambers Co
Address Riverdale, md
19. March 26, 1945 (Date rec'd by registrar) James Severe By R.S.S Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 24, 1945, at 10:55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 24, 1942, to Mar 24, 1945, and that I last saw her alive on Mar 24, 1945

Immediate cause of death	DURATION
Generalized adenocarcinoma	
Due to Primary in Uterus	3 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results Normal
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE W. E. Malin M.D. M. D., or other
Address Riverdale, Md. Date signed 3/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

03696

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince George

City or town Silver Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years

Hospital, Institution, or street address where death occurred: 3174 Branch Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Silver Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3174 Branch Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Nannie Bean

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife Frank Bean

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 29, 1843

8. AGE: Years 101 | Months 10 | Days 8 | If less than one day ..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Joseph Sweetney

13. Birthplace Maryland

MOTHER 14. Maiden name Anna Brawner

15. Birthplace Maryland

16. Informant Anna Jackson

Address 3174 Branch Ave R.F.

17. Burial, cremation or removal. Which? Removal Date thereof 3/9/45 (month) (day) (year)

Cemetery or crematory Charles Chapel

Location

18. Funeral director Mansfield

Address 600 - 2nd St. SW.

3/9 1945 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1945 at 3:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Congestive heart failure	
Due to Bronchopneumonia	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Deputy medical Examiner M. D. or other

Address Forestville Md. Date signed 3-7-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-b)

CERTIFICATE OF DEATH

03097

Reg. Dist. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo., 8 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 mo., 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1304 Kenyon St. N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: –

3. (a) FULL NAME: OSCAR BELL

3. (b) Social Security Number: 578-12-27519

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married (sep.)

6.(b) Name of husband or wife: Ella Bell

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): February 26, 1902

8. AGE: Years	Months	Days	If less than one day
43	1	2	...hrs. ...min.

8. Birthplace: Waynesburo, Georgia
(Town, county, and state)

10. Usual occupation: Shoemaker

11. Industry or business: –

FATHER
12. Name: Linwood Bell
13. Birthplace: Unknown

MOTHER
14. Maiden name: Carrie Thorns
15. Birthplace: Waynesburo, Georgia

16. Informant: Decedent
Address

17. removal (Burial, cremation, or removal. Which?) Date thereof April 2, 1945 (month) (day) (year)

Cemetery or crematory: D.C. Morgue

Location: 19th & C. St. S.E. Wash., D.C.

18. Funeral director: D.C. Morgue
Address

19. Mar. 28 1945 Rowland S. Phillips (Date rec'd by registrar) Deputy (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: MARCH 28 1945, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 20 1945, to March 28 1945

and that I last saw h... alive on March 28 1945

Immediate cause of death: Pulmonary tuberculosis — DURATION: 6 mos.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glen Dale, Md. Date signed: 3/28/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (732)

03698

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 days
Hospital, Institution, or street address where death occurred: Prince Geo. Hosp
How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: PG
City or town: Glenarden
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Bentley Mr Oscar

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
84			...hrs. ...min.

9. Birthplace: Petersburg, Va
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business
FATHER 12. Name: Bentley, W. D.
13. Birthplace: West. Va.
MOTHER 14. Maiden name: Brown, Mary
15. Birthplace: Petersburg, Va.
16. Informant: Hospital Record
Address: Prince Geo. Gen. Hosp.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-28-45 (month) (day) (year)
Cemetery or crematory: Rock Creek
Location: Washington D.C.
18. Funeral director: F. Gasch & Sons
Address: Hyattsville Md.
19. 3/27/45 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 26 1945, at 2:20 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 17 1945 to March 26 1945
and that I last saw h[illegible] alive on March 26 1945

	DURATION
Immediate cause of death: Chronic Myocarditis	1 yr
Due to: Nephritis	Unk
Due to: Stricture of urethra	50 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: Robert S McGeary M D
M. D. or other
Address: Laurel Md. Date signed 3/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

03699

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1945)

CERTIFICATE OF DEATH

Reg. Dist. No. 232

1. PLACE OF DEATH:
County: Prince George's
City or town: Upper Marlboro, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred: No
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Prince George's
City or town: Upper Marlboro Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: John Franklin Binger
3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Rose Loddard
Divorced
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 24 1865

8. AGE: Years: 80 | Months: 1 | Days: 4 | If less than one day: ___ hrs. ___ min.

9. Birthplace: Elimsport Pa (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Same

FATHER
12. Name: William Binger
13. Birthplace: Germany

MOTHER
14. Maiden name: Sarah J. Buchanan
15. Birthplace: Pa.

16. Informant: Charles R. Binger
Address: Upper Marlboro, Md

17. Burial (Burial, cremation, or removal) Which? Date thereof 3-31-45 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland, Md.
18. Funeral director: Pilkin Brothers
Address: Upper Marlboro, Md
19. March 31 1945 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 28 1945, at 8:05 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 1945 to Mar 28 1945 and that I last saw him alive on Mar. 28 1945

	DURATION
Immediate cause of death: Congestive Heart Failure	Week
Due to: Arteriosclerosis	10 yrs
Due to: Nephritis	2 yrs
Other conditions: Secondary Anemia	1 year

(Include pregnancy within 3 months of death)
Major findings of operations: None
Date of op.
Autopsy results: No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: James E. Spencer M. D. or other
Address: Upper Marlboro, Md Date signed 3-28-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (514)

CERTIFICATE OF DEATH

03100

Reg. Dist. No. 231

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Prince George

City or town Cheverly, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred:

Prince George General Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Geo.

City or town Brentwood

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3603 webster st.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Brady, miss Flora Louise

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31, 1903

8. AGE:

Years	Months	Days	If less than one day
42	2		hrs. min.

9. Birthplace Va. (Town, county, and state)

10. Usual occupation At home

11. Industry or business

FATHER

12. Name Brady, Mr. James D.

13. Birthplace Va

MOTHER

14. Maiden name Rector, Florence

15. Birthplace Va.

16. Informant Mrs. Pauline Marat (Sister)

Address 2506 - 28th St., N.E. Washington, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 31, 1945 (month) (day) (year)

Cemetery or crematory Ft Lincoln

Location Colmar Manor Md

18. Funeral director J Gaecha sons

Address Hyattsville Md.

19. 3/31 1945 Amanda Downey Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1945, at 2.4. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 20 1944, to March 28 1945, and that I last saw her alive on March 28 1945

Immediate cause of death	DURATION
Chronic Glomerulo-Nephritis	2 years.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles C. Ingage M. D.

M. D. or other

Address Mt. Rainier, Md. Date signed March 28 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

03102

Reg. Diat. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 8 - Rhode Island Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8 Rhode Island Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Ambrose Brown

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: Frances Brown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 28, 1890

8. AGE: Years: 55 | Months: 1 | Days: 15 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Landover Md (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: U. S Govt

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Agnes Conn

MOTHER — 15. Birthplace: Maryland

16. Informant: Agatha Brown

Address: 8 Rhode Island Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 20 1945 (month) (day) (year)

Cemetery or crematory: Mt Olivet

Location: Washington D C

18. Funeral director: J. Gadsden Sons

Address: Hyattsville Md

19. March 19 1945 (Date rec'd by registrar) James Sevier By R.S.S. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 15 1945 at 9:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Uremia	
Due to: Cardiovascular Renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Deputy medical Examiner James D. Sard M. D. or other

Address: Hyattsville Md Date signed 3-16-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of age is shown on

FILM G 94 MAY 15 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

CERTIFICATE OF DEATH

03101

Reg. Diat. No. 231

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Prince George
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 hrs
Hospital, institution, or street address where death occurred:
Prince George Gen Hospital
How long in hospital or institution? 2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Pr Geo
City or town Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4102 Gallatin st.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mr. Edward Bucklin

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Edna Bucklin
6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) March 30 1873

8. AGE: Years	Months	Days	If less than one day
72	11	23	hrs. min.

9. Birthplace Rebeck New Jersey
(Town, county, and state)
10. Usual occupation Real Estate Salesman
11. Industry or business

FATHER
12. Name Charles Bucklin
13. Birthplace N. J.

MOTHER
14. Maiden name Josephine Giles
15. Birthplace N. J.

16. Informant Wife Mrs Edna Bucklin
Address 4102 - Gallatin St. Hyatts

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 24 1945 (month) (day) (year)
Cemetery or crematory Fort Lincoln
Location Washington D.C.

18. Funeral director F Gresham sons
Address Hyattsville Md

19. 3/24 1945 Amanda Downes Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1945, at 7 20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 to Mar 22 1945 and that I last saw him alive on Mar. 22 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to hypertension of	
many years	
Due to	
Other conditions none	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Guy W. Patterson M.D.
M. D. or other
Address Hyattsville Date signed 3-22-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 87-D

03103

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Prince Georges City. Md.
City or town Kenilworth 2nd.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 year.
Hospital, institution, or street address where death occurred:
Home at 1505-49th Pl. Kenilworth.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)
State Maryland County Prince Georges.
City or town Kenilworth 2nd.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1505-49th Pl.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Willis augustus Bugbee.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife Edith Reid Bugbee.
6.(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) April 14. 1883.

8. AGE: Years 61 | Months | Days | If less than one day hrs. min.

9. Birthplace Minneapolis Minn.
(Town, county, and state)

10. Usual occupation clergyman.

11. Industry or business Church work.

FATHER
12. Name John Wilman Bugbee.
13. Birthplace Perry. Maine.

MOTHER
14. Maiden name Lida Caroline Norman
15. Birthplace Roberts. Maine.

16. Informant Edith R. Bugbee.
Address 1505-49th Pl. Kenilworth Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 22 1945 (month) (day) (year)

Cemetery or crematory George Washington Memorial
Location Rhode Road md

18. Funeral director F. H. Gassaway Sons
Address Hyattsville md

19. 3/19/1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18, 1945 at 4.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940, to 3-18 1945
and that I last saw h. alive on 3-18 1945

	DURATION
Immediate cause of death: Multiple Sclerosis	15 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

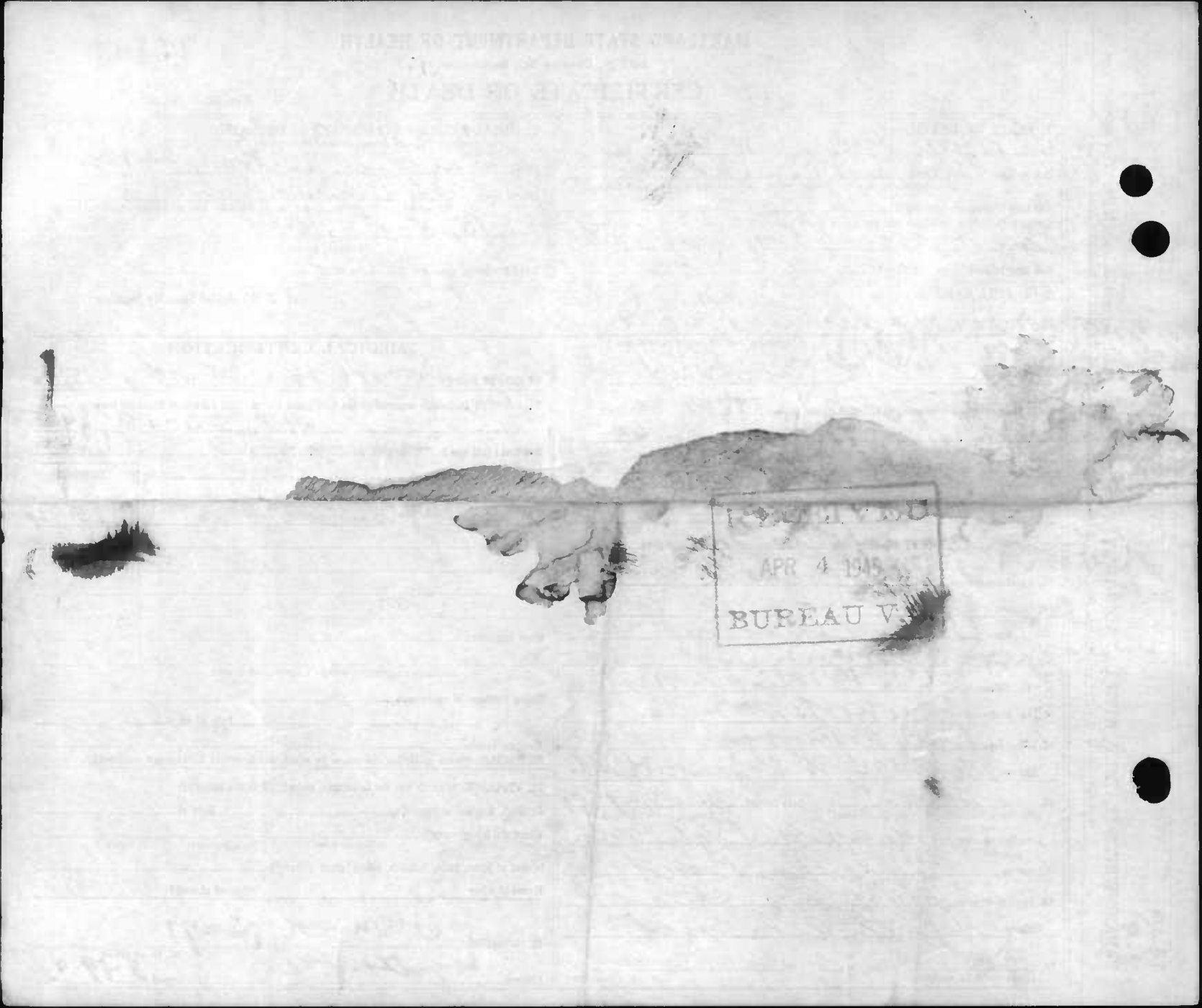
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Truman Hays M. D. or other
Address Hyatts. Md. Date signed 3-19-45

VS-A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.


APR 4 1945
BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

03104

CERTIFICATE OF DEATH

Reg. Dist. No. 23/2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH

County: Pr. Georges Co

City or town: Lanham Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Pr. Geo

City or town: Lanham Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Johanna Caemmerer

3.(b) Social Security Number

4. Sex Female

5. Color or race White

6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife: Frederick Caemmerer

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) April 13, 1860

8. AGE: Years: 84 | Months | Days | If less than one day: hrs. min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation At Home

11. Industry or business

FATHER

12. Name Alan Kott

13. Birthplace Germany

MOTHER

14. Maiden name Unknown

15. Birthplace Germany

16. Informant Clara Barth

Address Lanham Md

17. Transportation (Burial, cremation, or removal. Which?) Date thereof March 6, 1945 (month) (day) (year)

Cemetery or crematory Janesville Wisconsin

Location Janesville Wisconsin

19. Funeral director L. Gaeth & sons

Address Hyattsville Md

19 March 6 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1945, at 1.45 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 4 1945 to March 5 1945; and that I last saw h[illegible] alive on March 4 1945

	DURATION
Immediate cause of death: Cancer of the uterus (48)	2 yrs
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE Robert S. McCreary M.D. M.D. or other

Address Laurel Md Date signed 3/5/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9332

CERTIFICATE OF DEATH

03105 242
Reg. Dist. No.

[redacted]

1. PLACE OF DEATH:
County: Prince Georges
City or town: Chapel Oaks
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pr. Georges
City or town: Chapel Oaks
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1303-55-and,
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Edgar S. Chinn

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Lula Chinn
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 5, 1876

8. AGE: Years: 68 Months: Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Retired Govt. Employee
11. Industry or business: U.S. Govt.

FATHER
12. Name: Oscar Chinn
13. Birthplace: Va

MOTHER
14. Maiden name: Florence Penn
15. Birthplace: Va

16. Informant: Lula Chinn
Address: 1303-55 and,

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 19, 1945 (month) (day) (year)
Cemetery or crematory: Lincoln Cemetery
Location: Suitland, Md.
18. Funeral director: Arthur L. Tollins
Address: 4339 Hunt Pl. NE.

19. Mar. 14 — 1945 Irene A. Conner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 14 19 45 at 5:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 5 19 44 to March 14 19 45 and that I last saw h[illegible] alive on March 14 19 45

Immediate cause of death	DURATION
Hypostatic pneumonia	
Due to: Cardio-Vascular	7
Due to: Disease	
Other conditions: Arteriosclerosis ?	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: H. C. Bledsoe M. D. or other
Address: 4423 Hunt Pl. NE. Date signed: 3-16-45
Fairmont Hts.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

03106

CERTIFICATE OF DEATH

Reg. Diat. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Prince Georges.

City or town Riverdale, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 15 days.

Hospital, Institution, or street address where death occurred:
Eugene Leland Memorial Hospital

How long in hospital or Institution? 1 month, 19 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Takoma Park.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 403 E Than Allen Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Mrs Roberta Clark.

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Charles Randall Clark.

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) October 9th 1865

8. AGE: Years	Months	Days	If less than one day
79	5		hrs. min.

9. Birthplace Maryland.
(Town, county, and state)

10. Usual occupation retired

11. Industry or business —

FATHER
12. Name William Simpson
13. Birthplace England.

MOTHER
14. Maiden name Charlotte Rebecca Good
15. Birthplace Maryland.

16. Informant pt's chart.

Address

17. Burial Date thereof March 10, 1945.
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rock Creek Cemetery

Location Washington, D.C.

18. Funeral director Arthur Talbert.

Address 23rd & Carroll St, Takoma Park, D.C.

19. March 8, 1945 James L. Lewis
(Date rec'd by registrar) By [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8th 1945, at 6 00 A M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from 11/30 1944, to 3/8 1945 and that I last saw her alive on 3/7/45 1945

Immediate cause of death	DURATION
Generalized arteriosclerosis	10 yrs.
Due to Chronic nephritis	3 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. E. Malin, M.D.
M. D. or other

Address Riverdale, Md. Date signed 3/8/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03107

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince Georges

City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 hours 5 minutes

Hospital, Institution, or street address where death occurred:
Prince Georges General Hospital

How long in hospital or Institution? 5 hours 5 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County: —

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1421 Pennsylvania Ave. S.E., Wash, D.C.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Ethel Welch Coffelt

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband ~~or wife~~: Mr. John H. Coffelt.

6.(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): January 20, 1899.

8. AGE: Years	Months	Days	If less than one day
46	2	7	....hrs. ....min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business:

FATHER
12. Name: Not Known.
13. Birthplace:

MOTHER
14. Maiden name: Mollie M. Welch.
15. Birthplace: Virginia

18. Interment: Mr. John H. Coffelt
Address: 1421 Pennsylvania Ave, S.E. Wash, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3-30-45 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va

18. Funeral director: H. H. Chambers Co

Address: 517-11-St. S.E.

19. 3/28/1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27 1945 at 10:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 24 1945 to Mar 27 1945 and that I last saw h.. alive on Mar 27 1945

Immediate cause of death	DURATION
a Lobar pneumonia	3 days
Due to	
Due to	
Other conditions: Acute infections Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results: Lobar pneumonia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: .... Date of ....

Where did injury occur? .... (City or town) .... (County) .... (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... Injured at work?

23. SIGNATURE: W. M. Nace M.D.
M. D. or other

Address: 666 Mass Ave NE Wash DC Date signed: 3/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

03108

Reg. Dist. No. 231

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Prince Georges

City or town: Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 days

Hospital, institution, or street address where death occurred: Prince Georges General Hospital

How long in hospital or institution? 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Suitland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4802 - Suitland Rd., S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Flora Etta Crosier

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 1874

8. AGE:

Years	Months	Days	If less than one day
70	11		..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER
12. Name: Horace Crosier
13. Birthplace: Massachusetts

MOTHER
14. Maiden name: Carrie May
15. Birthplace: Vermont

16. Informant: Mrs. Harry West
Address: 4802 Suitland Rd, S.E.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 13-45 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Suitland Md.

18. Funeral director: Sloman F. Murray

Address: 2017 - Nichols Ave S.E.

19. March 11 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 11 1945 at 9:45 A M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Jan 1 1945 to March 11 1945

And that I last saw her alive on March 10 1945

	DURATION
Immediate cause of death: Acute myocardial decompensation	1 day
Due to: Cardiovascular Renal Disease	unknown
Due to:	
Other conditions: Chronic Endocarditis	unknown

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Paul Van Natta M. D. or other

Address: Washington 19 D.C. Date signed: 3/11/45

age unknown to physician

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

03109

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred:
Prince George General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince George
City or town: Bowie
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Lewis E DePriest

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	widowed

B.(b) Name of husband or wife
B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 25, 1858

8. AGE: Years: 86 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: William DePriest
13. Birthplace: Virginia

MOTHER — 14. Maiden name: Betty Wilkins
15. Birthplace: Virginia

16. Informant: Henry A. DePriest
Address: Bowie Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 14 1945 (month) (day) (year)
Cemetery or crematory: Family Cemetery
Location: Laurel Md. R. 1
18. Funeral director: Whitten Funeral Home
Address: 1536 Park Ave Laurel Md.

19. March 13 1945 (Date rec'd by registrar) James Severe By R.S.S. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-12 1945, at 5-25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-7- 1945, to 3-12 1945;
and that I last saw h[illegible] alive on 3-12 1945.

Immediate cause of death	DURATION
Bronchopneumonia	
Due to	
Due to Fracture due to accidental fall, March 7th, 1945 C.W.R.	
Other conditions Fracture of neck of left femur.	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: [signature] M.D.
M. D. or other
Address: Hyattsville Md. Date signed: 3-14-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

03110

CERTIFICATE OF DEATH

Reg. Diat. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 days
Hospital, institution, or street address where death occurred:
Prince Georges General Hospital
How long in hospital or institution? 17 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Croom Station
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William Cornelius Duley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mrs. Alice R. Duley
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Nov. 17, 1858

8. AGE:

Years	Months	Days	If less than one day
86	3	15	hrs. min.

9. Birthplace: Maryland Prince George Co.
(Town, county, and state)
10. Usual occupation: retired farmer.
11. Industry or business

FATHER
12. Name: William Washington Duley
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Susan Sansbury
15. Birthplace: Maryland.

16. Informant: Mrs. Alice R. Duley
Address: Croom Station, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3 4 45 (month) (day) (year)
Cemetery or crematory: Mt Carmel
Location: Upper Marlboro Md

18. Funeral director: Ritchie Bros
Address: Upper Marlboro Md

19. March 4 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 4 1945, at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 14 1945 to March 4 1945
and that I last saw him alive on March 4 1945

Immediate cause of death	DURATION
Bronchial Pneumonia	2 days
Due to: Arteriosclerosis	20 yrs
Due to: Uremia	2 hrs
Other conditions: Hypertrophic Prostatectis	One month

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op. —
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of —
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: None Injured at work? —

23. SIGNATURE: James E. Isaacs M.D.
M. D. or other
Address: Upper Marlboro Date signed 3-4-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-E)

03111

CERTIFICATE OF DEATH

Reg. Dist. No. 243

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 mos., 10 days

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 11 mos., 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No.: 1747 F. St. N. W. (If rural, give LOCATION)

2.(a) If veteran, name war: -

3.(a) FULL NAME: Winnie S. Farris

3.(b) Social Security Number: 415-22-0347

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married (sep.)

6.(b) Name of husband or wife: B.F. Farris

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): January 20, 1919

8. AGE:	Years	Months	Days	If less than one day
	26	2	10	hrs. min.

9. Birthplace: Orlinda, Tennessee (Town, county, and state)

10. Usual occupation: Stenographer

11. Industry or business:

FATHER — 12. Name: Joe Shoulders

13. Birthplace: Adairville, Kentucky

MOTHER — 14. Maiden name: Sarah Jones

15. Birthplace: Lafayette, Tennessee

16. Informant: Decedent

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: March 30, 1945 (month) (day) (year)

Cemetery or crematory: [illegible] Orlinda,

Location: Tennessee

18. Funeral director: W. W. Chambers Co.

Address: 517 11th St S.E.

19. Mar. 30 1945 (Date rec'd by registrar) Rowland S Phillips Dep. Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30 1945, at 8:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 20 1944, to March 30 1945; and that I last saw her alive on March 30 1945

Immediate cause of death: Pulmonary tuberculosis — DURATION: 2 yr 2 mo

Due to:

Due to:

Other conditions: (Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Pinncane M.D. (M. D. or other)

Address: Glenn Dale, Md. Date signed: 3/30/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 169

03112

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Prince Geo.
City or town Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: - New born
(For newborn infants give residence of mother)
State County
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Gaither

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	New born

6.(b) Name of husband or wife
6.(c) If olive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 15 1945 1 45 am

8. AGE: Years	Months	Days	If less than one day
New born			1 hrs. 40 min.

9. Birthplace Prince Geo. Hospt.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Galt, Mr. Cecil
13. Birthplace Pa.

MOTHER
14. Maiden name Marion Fink
15. Birthplace Md.

16. Informant Marion Fink Gaither
Address Brandywine, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof March 17, 1945 (month) (day) (year)

Cemetery or crematory Prince George's General Hospital
Location Cheverly, Md.

18. Funeral director C. K. Beeley Supt. Prince George Hospital
Address Cheverly Md.

19. March 17 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15, 1945, at 3:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15 1945 to 1945
and that I last saw h. l. alive on March 15 1945

Immediate cause of death	DURATION
Prematurity	
Due to	
Due to	
Other conditions L.M.P. of mother 10/5/44. Baby born 3/15/45	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE ISIDOR M. LEVINE M. D. or other
Address MT. RAINIER, MD Date signed 3-15-45.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (K3-H)

CERTIFICATE OF DEATH

03113

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Georges
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred: 6108 Baltimore Boulevard
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6108 - Baltimore Boulevard
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Edna Leigh Gordon

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Harry R. Gordon
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 13, 1917

8. AGE: Years	Months	Days	If less than one day
28	2.	2	hrs. min.

9. Birthplace: Coleridge N. C.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home
FATHER 12. Name: James F Deaton
FATHER 13. Birthplace: N. C.
MOTHER 14. Maiden name: Unknown
MOTHER 15. Birthplace: Unknown
16. Informant: Harry R. Gordon
Address: 6108 - Baltimore Blvd
17. (Burial, cremation, or removal. Which?) transportation
Date thereof: March 16, 1945 (month) (day) (year)
Cemetery or crematory: Asheboro N.C
Location: North Carolina
16. Funeral director: F Gaschie sons
Address: Hyattsville Md
19. March 16, 1945 (Date rec'd by registrar)
James Severe By R.S.S. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 15 1945, at 7 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Asphyxia	
Due to, Acute Carbon Monoxide	
Poisoning	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of 3-15-45
Where did injury occur? Hyattsville (City or town) P. G. (County) Md. (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury: Injured Gas jet Injured at work? No

Deputy Medical Examiner
23. SIGNATURE: James F. C. Boyd M. D. or other
Address: Forestville md Date signed 3-15-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

03114

Reg. Dist. No. 239

WITHIN CORPORATE LIMITS OF

1. PLACE OF DEATH

County Pr Geo

City or town Laurel Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs

Hospital, institution, or street address where death occurred

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Pr Geo

City or town Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No. 312 - 4th St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Charles Roy Gosnell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Florence Gosnell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 24 - 1875

8. AGE: Years 69 | Months 8 | Days 15 | If less than one day ..... hrs. ..... min.

9. Birthplace Frederick Md

(Town, county and state)

10. Usual occupation Retired Watchman

11. Industry or business Md State Rd Com -

12. FATHER Name Elias S. Gosnell

13. Birthplace Md

14. MOTHER Maiden name Mary Van Pelt

15. Birthplace Md

16. Informant Florence Gosnell

Address 312 - 4th St. Laurel Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-11-45 (month) (day) (year)

Cemetery or crematory Savage Md

Location Savage Md

18. Funeral director Del Pitt Davidson

Address Laurel Md

19. May 11 19 45 M. Brashears

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 9 19 4 at 9:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 9 19 4 to 3 9 19 4 and that I last saw h... alive on 3 9 19 4

	DURATION
Immediate cause of death Coronary Thrombosis	
Due to Arteriosclerosis	
Due to Hypertension	
Other conditions Chr Myocarditis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B Adams M. D. or other

Address Laurel Md Date signed 3 9 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (75-E)

CERTIFICATE OF DEATH

03115

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince Georges
City or town: Lanham (If outside city or town limits, write RURAL and give nearest town) Md. R.F.D. No. 1 Box 32
How long in above place of death? 30 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Lanham Md. R.F.D. No. 1 Box 32 (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Adeline Hall

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	Widow

6.(b) Name of husband or wife: George Hall (deceased) 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 30, 1872

8. AGE: Years 72 | Months 9 | Days 25 | If less than one day ..... hrs. ..... min.

9. Birthplace: Franklin Co. Mississippi (Town, county, and state)
10. Usual occupation: Housekeeper
11. Industry or business: Own home

FATHER
12. Name: ——— Washington
13. Birthplace: Mississippi

MOTHER
14. Maiden name: Kissie
15. Birthplace: Mississippi

16. Informant: Carrie Maynard (daughter)
Address: Lanham Md. R.F.D. No. 1 Box 32

17. Removal (Burial, cremation, or removal. Which?) Date thereof: March 25 45 (month) (day) (year)
Cemetery or crematory
Location
18. Funeral director: Geo. E. Shade & Shade
Address: Wayside Md.

19. March 25 19 45 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 25 19 45 at 7:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17 19 45 to Mar. 25 19 45 and that I last saw h... alive on March 24 19 45

Immediate cause of death: Myocarditis (acute)

	DURATION
Due to: Rheumatic heart.	1 yr.
Due to: Acute nephritis	1 yr.
Other conditions	

(Includo pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: W. W. Spiller M.D. (M. D. or other)
Address: Brentwood, Md. Date signed: 3-25-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

03116

CERTIFICATE OF DEATH

Reg. Dist. No. 142

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Prince Georges
City or town Hellsdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
837 - 59th Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Hellsdale
(If outside city or town limits, write RURAL and give nearest town)
Street No. 837 - 59th Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Kelley Y. Cornelius Harris

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

B.(b) Name of husband or wife Alice Harris
B.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 16, 1884

8. AGE: Years 60 | Months 10 | Days 29 | If less than one day ..... hrs. ..... min.

9. Birthplace Georgetown DC (Town, county, and state)
10. Usual occupation Retired Lineman
11. Industry or business Potomac Electric Power Co
FATHER 12. Name Edward Harris
13. Birthplace District of Columbia
MOTHER 14. Maiden name unknown
15. Birthplace unknown
16. Informant Mrs Thelma Harper
Address 837-59th Ave, Hellsdale, md

17. Burial, cremation, or removal. Which? Burial Date thereof 3/19/45 (month) (day) (year)
Cemetery or crematory Addison Chapel
Location Seat Pleasant Md
18. Funeral director L. L. Chambers Co
Address 517-11th St SE

19. March 17 1945 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1945, at 4:15 P. M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to Cardio vascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at (work)?

23. SIGNATURE Deputy Medical Examiner James H Young M. D. or other
Address Forestville Md Date signed 3-15-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

0311?

Reg. Dist. No. 242

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH:
County: Prince Georges
City or town: Suitland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? worked here for 2 years
Hospital, institution, or street address where death occurred: Hydrographic Office
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: District of Columbia
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1347 - Maryland Ave N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I. ✓

3.(a) FULL NAME: Fredrick Otto Hasslacher

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Segrue Hasslacher
6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): January 9, 1887

8. AGE: Years: 58 | Months: 2 | Days: | If less than one day: hrs. min.

9. Birthplace: New York City, N.Y. (Town, county, and state)
10. Usual occupation: Lithographer
11. Industry or business: U. S. Govt.
FATHER 12. Name: Unknown
13. Birthplace: New York
MOTHER 14. Maiden name: Unknown
15. Birthplace: New York
16. Informant: Lorraine Hasslacher
Address: 1347 Md Ave N.E., Washington
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3/10/45 (month) (day) (year)
Cemetery or crematory: Arlington Natl
Location: Arlington Va.
18. Funeral director: H. M. Saunders Co.
Address: 517 11th St. S.E.
19. 3-8-45 (Date rec'd by registrar) 19 Irene A. Bowers Registrar

MEDICAL CERTIFICATION 1945

20. DATE OF DEATH: March 7, 19 45, at 8 50 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to: Cardio Vascular renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?
23. SIGNATURE: James J. Boyd, Deputy Medical Examiner
M. D. or other
Address: Forestville Md. Date signed: 3-7-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

03118

CERTIFICATE OF DEATH

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK (M) Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: PRINCE GEORGE
City or town: CAMP SPRINGS
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 YRS
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: PRINCE GEO.
City or town: CAMP SPRINGS
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 7241 BRINKLEY ROAD
(If rural, give LOCATION)
2.(a) If veteran, name war: NONE

3.(a) FULL NAME: EDITH E HAYDEN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6.(b) Name of husband or wife: FRED A HAYDEN
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): JAN 2 - 1875

8. AGE: Years: 70 | Months: | Days: | If less than one day: ____ hrs. ____ min.

9. Birthplace: MAINE (Town, county, and state)
10. Usual occupation: HOUSEWIFE
11. Industry or business: NONE

FATHER
12. Name: MARCELLUS EUGULEY
13. Birthplace: MAINE

MOTHER
14. Maiden name: ALICE M ?
15. Birthplace: MAINE

16. Informant: FRED A. HAYDEN
Address: 1741 BRINKLEY RD S.E. WASH. D.C.

17. REMOVAL (Burial, cremation, or removal. Which?) Date thereof: MARCH 3 1945 (month) (day) (year)
Cemetery or crematory:
Location: WASHINGTON D.C.

18. Funeral director: W. W. Chambers Co.
Address: 5/7 11th St S.E.

19. 3-4- 19 45 (Date rec'd by registrar) Thos. D. Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MARCH 3rd 19 45 at 5 20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 19 45 to March 3 19 45 and that I last saw h.er alive on March 3 19 45

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 mo
Due to: General Arteria - Sclerosis	unknown
Due to: —	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Dane C Van Matre M. D. or other
Address: Washington 19 DC Date signed: March 4 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03119

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Prince Georges
City or town Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred 4907 - Queensberry Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Riverdale
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4907 Queensberry Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Fred W. Heid

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Eva M Heid
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10, 1889

8. AGE: Years 56 | Months 0 | Days 20 | If less than one day hrs. min.

9. Birthplace Youngstown, Ohio
(Town, county, and state)

10. Usual occupation Retired Printer

11. Industry or business

FATHER 12. Name unknown
13. Birthplace unknown

MOTHER 14. Maiden name unknown
15. Birthplace unknown

16. Informant Eva M Heid
Address Riverdale, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 3, 1945 (month) (day) (year)
Cemetery or crematory Mt. Olivet
Location Washington D C

18. Funeral director J Gaeta's sons
Address Hyattsville Md.

19. April 2 1945 Jos Sevey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1945 at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Asphyxia	
Due to Acute Carbon Monoxide	
Poisoning	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 3-30-45
Where did injury occur? Riverdale (City or town) P.G. (County) Md. (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury Turned gas jets on Injured at work? No

Regular Medical Examiner

23. SIGNATURE [illegible] M. D. or other
Address Forestville Md. Date signed 3-30-45

Evidence for change of age is shown on FILM No G 9 4 MAY 15 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-a)

CERTIFICATE OF DEATH

03120 Reg. Diat. No. 231

1. PLACE OF DEATH:
County: Prince George County.
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 hours.
Hospital, institution, or street address where death occurred:
Prince George General Hospital
How long in hospital or institution? 8 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Colmor Manor
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3601 - 42 ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Minnie James.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 31 1872

8. AGE: Years	Months	Days	If less than one day
72	11	7	hrs. min.

9. Birthplace: Virginia
(Town, county, and state)
10. Usual occupation: Home wife
11. Industry or business
12. FATHER Name: William Granville
13. FATHER Birthplace: unknown
14. MOTHER Maiden name: "
15. MOTHER Birthplace: "
16. Informant: Mrs. Pearl Breeden
Address: 3601-42 ave - Colmor Manor, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 9, 1945 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland Md
18. Funeral director: F. Gracie sons
Address: Hyattsville Maryland.
19. 3/8 (Date rec'd by registrar) 19 45 Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 7 19 45, at 5 45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 3 19 44, to March 7 19 45
and that I last saw h alive on 19

Immediate cause of death	DURATION
(a) Malignant Hypertension & Uraemic Poisoning	10 days
Due to: Chronic interstitial nephritis. Duration: Unknown. C.W.B.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: George Heggeness M.D.
M. D. or other
Address: 2717-38th Ave Date signed: 3-7-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-A)

CERTIFICATE OF DEATH

03121

Reg. Diat. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Prince Georges
City or town Berwyn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 1/2 years
Hospital, Institution, or street address where death occurred:
9223 - Baltimore Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Berwyn
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9223 Baltimore Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME LINA AGNES KLATT

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Robert A Klatt
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 22, 1862

8. AGE: Years	Months	Days	If less than one day
82	11	4	..... hrs. ..... min.

9. Birthplace Germany (Town, county and state)
10. Usual occupation none
11. Industry or business Housewife
FATHER 12. Name Gotlieb Konrad
13. Birthplace Germany
MOTHER 14. Maiden name Edmuthe Fabe
15. Birthplace Germany
16. Informant Ida C Mead
Address 9223 - Baltimore Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-29-45 (month) (day) (year)
Cemetery or crematory Parkwood Cemetery
Location Baltimore, Maryland
18. Funeral director HENRY SANDER & SONS, INC.
Address NORTH AVE. & BROADWAY
19. 3/28/45 (Date rec'd by registrar) A. W. Hedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 19 45, at 10:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Coronary occlusion	
Due to Cardiovascular renal disease	
Due to	
Other conditions	
(Include pregnancy within 3 months of death)	

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

Deputy Medical Examiner
23. SIGNATURE James J. Boyd M. D. or other
Address Forestville, Md. Date signed 3-26-45

Rec'd. U.S. -
3/28/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

03122

Reg. Diat. No. 242

1. PLACE OF DEATH:
County: Prince Georges
City or town: Dupont Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, Institution, or street address where death occurred: Porter Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Dupont Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Porter Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Harry Lancaster

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: Wealthy Lancaster
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE:	Years	Months	Days	If less than one day
	64			hrs. min.

9. Birthplace: Scotland, Maryland
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: General
FATHER 12. Name: Unknown
13. Birthplace: Unknown
MOTHER 14. Maiden name: Sarah Lancaster
15. Birthplace: Maryland
16. Informant: Albert Lynn
Address: Dupont Heights, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof March 18 45 (month) (day) (year)
Cemetery or crematory: Palmer Cemetery
Location: Bennig Rd. NE
18. Funeral director: J. B. Logan
Address: Annapolis
19. 3-17 1945 (Date rec'd by registrar) Irene G. Commer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 14 1945 at 3 05 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Uremia	
Cardio Vascular	
renal disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?
Deputy medical Examiner
23. SIGNATURE: James J. Lough M. D. or other
Address: Forestville Md Date signed 3-14-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

03123

Reg. Diat. No. 239

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: WITHIN CORPORATE LIMITS OF

County: Prince Geo

City or town: Laurel

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Geo

City or town: Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No. 340 Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Lillie E. Lawson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Adelbert Lawson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 1- 1889

8. AGE:

Years	Months	Days	If less than one day
55	6	5	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Luther G. Burdette

13. Birthplace: Md

MOTHER

14. Maiden name: Ellen R. Cutsail

15. Birthplace: Md

16. Informant: Harold Lawson

Address: Laurel Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mch 8-45 (month) (day) (year)

Cemetery or crematory: Hyattstown

Location: Hyattstown Md

18. Funeral director: Lloyd Riner

Address: Laurel Md

19. March 8 19 45 Cora E Wachter Deputy Registrar

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mch 6- 1945 at 2a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mch 1- 45 to Mch 6- 45

and that I last saw her alive on March 5- 45 19..

Immediate cause of death	DURATION
Coronary Thrombosis	1 hr
Due to Hypertension - Arterio Sclerosis	4 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W B Lemmon M. D. or other

Address: Laurel Md Date signed March 7 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 176-2

CERTIFICATE OF DEATH

03124

Reg. Dist. No. 239

1. PLACE OF DEATH:

County: Prince George's — IN CORPORATE LIMITS OF

City or town: Laurel

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Transient

Hospital, institution, or street address where death occurred:

Washington Blvd. and Bowie Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland — County: Howard

City or town: Fulton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Leroy Stanton Lewis

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 28, 1924

8. AGE:

Years	Months	Days	If less than one day
20	2	5	..... hrs. ..... min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: Jesse J. Lewis

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Nettie V. Pierpont

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs. Nettie Lewis

Address: Fulton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 7-1945 (month) (day) (year)

Cemetery or crematory: Emmanuel

Location: Scaggsville, Maryland

18. Funeral director: Lloyd Kaesi

Address: Laurel, Maryland

19 March 7 '45 (Date rec'd by registrar) Cora E. Wachter, Deputy — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 5 19 45, at 12:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to: Crushed skull, crushed chest, fractured pelvis and femur	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident — Date of 3/5/45

Where did injury occur? Laurel (City or town) P. G. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Route #1

Means of injury: In collision with — Injured at work? No

Deputy Medical Examiner

23. SIGNATURE: James S. Bowen M. D. or other

Address: Forestville, Md. — Date signed 3/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-C)

CERTIFICATE OF DEATH

County or typ. card 03125 Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince Geo.
City or town: Ritchie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant give residence of mother)
State: Maryland County: Prince Geo.
City or town: Ritchie
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6920 White House Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: CHRISTOPHER C LUSBY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Ada M. Lusby.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 26th 1873

8. AGE: Years	Months	Days	If less than one day
71			hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:
12. Name of FATHER: Henry Lusby.
13. Birthplace of FATHER: Md.
14. Maiden name of MOTHER: Elizabeth Sarlet
15. Birthplace of MOTHER: Md.
16. Informant: Mr Walter Lusby.
Address: 6920 White House Rd.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-12-45 (month) (day) (year)
Cemetery or crematory: Episcopal Church Yard
Location: Forestville Md.
18. Funeral director: W. H. Chambers Co.
Address: 517 11th St N.E.
19. Mar 9th 1945 (Date rec'd by registrar) Thos D Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 8 1945 at 10:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 7 1945 to March 8 1945 and that I last saw him alive on March 7 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 hrs
Due to: Hypertension	8 yrs
Due to: Nephritis	3 yrs
Other conditions: Arteriosclerosis	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.
Autopsy results: No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James E. Sasscer M. D. or other
Address: Upper Marlboro Date signed 3-8-45

M

I

T

VS A 15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-0)

CERTIFICATE OF DEATH

Reg. Dist. No. 03126 42

Corrected on typ. card

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Prince Georges

City or town Cedar Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 Years

Hospital, Institution, or street address where death occurred

6757 Livingston Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Cedar Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6757 - Livingston Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James Fredrick Marshall

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Sarah Marshall

6.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Jan 1, 1871

8. AGE: Years 74 | Months 2 | Days 13 | If less than one day ..... hrs. ..... min.

9. Birthplace Charles County, Md (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Farm

FATHER 12. Name Bruce Marshall

13. Birthplace Maryland

MOTHER 14. Maiden name Unknown

15. Birthplace Maryland

16. Informant Sarah Marshall

Address 6757 - Livingston Road

17. Removal. (Burial, cremation, or removal. Which?) Date thereof 3-14-45 (month) (day) (year)

Cemetery or crematory

Location Woodlawn 5 R.

18. Funeral director John T. Stewart

Address 36 - H - St. N.W. D.C.

19. 3/14 19 45 Thos D Griffith Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 19 45, at 1 00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to Cardio Vascular Renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Deputy medical Examiner James J. Ford M. D. or other

Address Forestville Md Date signed 3-13-45

Change of items 7 & 8.
Film No. G94. 4/13/45. C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

03127

Reg. Diat. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 days.
Hospital, institution, or street address where death occurred: Prince George Gen. Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince George
City or town: 3703 Taylor St
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Brentwood.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John Mc. Clary

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Ruth Ann McClary
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 13 1873

8. AGE: Years	Months	Days	If less than one day
71	4	12	hrs. min.

9. Birthplace: Indiana (Town, county, and state)
10. Usual occupation: glass cutter
11. Industry or business:

FATHER
12. Name: James Mc. Clary
13. Birthplace: Indiana

MOTHER
14. Maiden name: Elizabeth Drumbaugh
15. Birthplace: Indiana

16. Informant: Hospital Records
Address: Prince George Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3 - 15 - 1945 (month) (day) (year)
Cemetery or crematory: Fort Lincoln Cemetery
Location: Bladensburg Rd. & D.C. Line
18. Funeral director: William J. Malley
Address: 3200 - R.I. Ave. Mt. Rainier, Md.
19. 3/14 1945 (Date rec'd by registrar) Amanda Downes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-12 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-3 1945, to 3-12 1945
and that I last saw h[illegible] alive on 3-12 1945

Immediate cause of death	DURATION
Coronary Occlusion	
Arterio Sclerosis	2 months +
Due to: Coronary Artery disease	
with Arteriosclerosis	7 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M.D.
M. D. or other
Address: Mt. Rainier Md. Date signed: 3-13-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Wa. 1634

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-E)

03128

CERTIFICATE OF DEATH

Reg. Diat. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: Glenn Dale, Maryland (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mos., 11 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 3 mos., 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1816 T. St. N. W., Apt. #2.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: MC INTOSH, LEON

3. (b) Social Security Number: 578-16-8475

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	mar.

6.(b) Name of husband or wife: Josephine McIntosh
6.(c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): August 19, 1907

8. AGE:

Years	Months	Days	If less than one day
37	7	1	...hrs. ...min.

9. Birthplace: Florence, South Carolina (Town, county, and state)
10. Usual occupation: Car Washer (Orr's Garage)
11. Industry or business:

FATHER
12. Name: Henry McIntosh
13. Birthplace: Florence, South Carolina

MOTHER
14. Maiden name: Julia Kelley
15. Birthplace: Florence, South Carolina

16. Informant: Decedent
Address:

17. Removal to (Burial, cremation, or removal. Which?) Date thereof: Mar. 20, 1945 (month) (day) (year)
Cemetery or crematory:
Location: Washington, D.C.
18. Funeral director: Robert E. McGuire
Address: 1820-9 to 24 N.W.

19. Mar. 20, 1945 (Date rec'd by registrar) Rowland L. Phillips Registrar
Dep Coroner

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 20, 1945, at 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/9 1944, to 3/20 1945
and that I last saw h... alive on 3/20 1945

Immediate cause of death	DURATION
Tuberculosis pulmonary	8 mos.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: 3/20/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

03129

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince Georges
City or town: Capitol Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Capitol Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 601-48th Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I

3. (a) FULL NAME: Wilbur Martin Miller

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Mabel Elizabeth Miller
6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): August 29, 1889

8. AGE: Years	Months	Days	If less than one day
55			..... hrs. ..... min.

9. Birthplace: Cortland New York.
(Town, county, and state)
10. Usual occupation: Chief Commissary Steward
11. Industry or business: U.S. Navy.
FATHER 12. Name: Martin Miller
FATHER 13. Birthplace: New York State
MOTHER 14. Maiden name: Jennie Carr
MOTHER 15. Birthplace: New York State
16. Informant: Mrs. Mabel Eliz. Miller
Address: 601-48th Ave, Capitol Heights Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3-10-45 (month) (day) (year)
Cemetery or crematory: Arlington Natl.
Location: Arlington Va
18. Funeral director: W. W. Chambers Co
Address: 617 11th St S.E.
19. March 7 1945 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 6 1945, at 3:30 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 5 1945 to March 6 1945
and that I last saw him alive on March 5 1945
Immediate cause of death: Coronary thrombosis — DURATION: 7 hours
Due to:
Due to:
Other conditions: Diabetes mellitus — 18 years
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William Brannin M. D.
Address: Capitol Heights, Md (town) Date signed: 3/6/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

3/6/45

Coroner Boyd notified & consent for cremation of certificate given.

William Brannin, MD

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73-C

03130

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince Georges
City or town: Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, Institution, or street address where death occurred: Prince Georges General Hospital
How long in hospital or Institution? 2 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4404 Madison St.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War #2

3.(a) FULL NAME: Mr. Carl Vernon Moore

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): January 13-1919

8. AGE:

Years	Months	Days	If less than one day
26	2	2	..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: Frank Moore
13. Birthplace: W. Va

MOTHER — 14. Maiden name: Iola Pollard
15. Birthplace: Va.

16. Informant: Mrs. Iola Moore.
Address: 4404 Madison St, Hyattsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-14-44 (month) (day) (year)
Cemetery or crematory: Ft. Lincoln Cemetery
Location: Wash D.C.

18. Funeral director: W W Chambers Co.
Address: Riverdale Md.

19. 3/12 1945 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-11 1945 at 11:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-9 1945 to 3-11 1945
and that I last saw him alive on 3-10 1945.

Immediate cause of death	DURATION
Cerebral Hemorrhage Due to Myocardial Insufficiency & Myocarditis Chronic	
Due to Rheumatic Heart Disease	
Due to	
Other conditions Chronic Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Albert E. Ed. M. D. or other
Address: Hyattsville, Md. Date signed 3-11-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

03131

Reg. Diat. No. .....

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 3 mos., 20 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 yr., 3 mos., 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County: .....
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 496- Maryland Ave., S.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3. (a) FULL NAME: MURRAY WILLIAM

3. (b) Social Security Number: 220-07-4559

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Rose Murray (dec.)
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 8, 1903

8. AGE:

Years	Months	Days	If less than one day
41	7	14	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: Metal worker
11. Industry or business:

FATHER
12. Name: George Murray
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Jeanette Hatcher
15. Birthplace: Washington, D. C.

16. Informant: Decedent
Address:

17. Removal to (Burial, cremation, or removal. Which?) Date thereof Mar. 22 1945 (month) (day) (year)
Cemetery or crematory:
Location: Washington, D.C.
18. Funeral director: Harold J. Taltavull
Address: 436-7th St. S.W. Wash. D.C.

19. Mar. 22 1945 (Date rec'd by registrar) Rowland S. Phillips Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 22 1945, at 8:25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 31 1943, to March 22 1945 and that I last saw him alive on March 22 1945

	DURATION
Immediate cause of death: Tuberculosis, pulmonary	3½ yrs.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: 3/22/45

Evidence for change of age is shown on FILM No. G 9 4 MAY 15 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

03132

Reg. Diat. No. 245

1. PLACE OF DEATH:
County: Prince George
City or town: Hyattsville, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 MO 17 DAYS
Hospital, institution, or street address where death occurred:
SACRED HEART HOME
How long in hospital or institution? 1 MO. 17 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: WASHINGTON
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2701 CONN. AVE N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: AGNES V. NELSON

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Wellington M. Nelson
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Mar 8, 1861

8. AGE: Years	Months	Days	If less than one day
84	4 3		..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: None
11. Industry or business:
FATHER 12. Name: John Landrigan
13. Birthplace: Ireland
MOTHER 14. Maiden name: Honora O'Shaughnessy
15. Birthplace: Ireland
16. Informant: Sacred Heart Home Records
Address: Hyattsville Md
17. Removal (Burial, cremation, or removal. Which?) Date thereof 3-27-45 (month) (day) (year)
Cemetery or crematory: Mt Olivet Cemetery
Location: Washington D.C.
18. Funeral director: Francis J Kelly
Address: 3821-14th St NW Wash DC.
19. March 22, 1945 (Date rec'd by registrar) James Severe By R.S.S. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 22 19 45 at 10 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 19 19 45 to Mar 22 19 45
and that I last saw her alive on Mar 21 19 45

Immediate cause of death	DURATION
(a) Apoplexy	3 days
Due to: Hypertension	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Thomas Hallin MD (M. D. or other)
Address: 325 H St N.E. Date signed 3-27-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

03133

Reg. Dist. No. 245

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County Prince George's

City or town Riverdale Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, Institution, or street address where death occurred:

Leland Memorial Hospital

How long in hospital or Institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 100 Fourth Ave.,

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mr. Robert Joseph. Norton

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widowed

6.(b) Name of husband or wife Marion C. Norton.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 9, 1861

8. AGE: Years	Months	Days	If less than one day
83.	3	2	..... hrs. ..... min.

9. Birthplace Silver, Maryland. (Town, county, and state)

10. Usual occupation Caretaker of Cemetery

11. Industry or business

FATHER 12. Name Robert L. Norton

13. Birthplace in Maryland

MOTHER 14. Maiden name Emanuel

15. Birthplace Maryland.

16. Informant Robert L. Norton (Son)

Address 100 Fourth ave., Tk. Pk. md

17. Removal (Burial, cremation, or removal. Which?) Date thereof 3 12 46 (month) (day) (year)

Cemetery or crematory Mt. Olivet Chapel Md

Location Washington D. C.

18. Funeral director W. W. Chambers

Address Riverdale md

19. March 12, 1946 (Date rec'd by registrar)

James Green By R.S.S. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/12 1946 at 10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/10 1945 to 3/12 1945 and that I last saw him alive on Mar 11 1945

Immediate cause of death	DURATION
Cardio-Vascular-renal disease	3 mos
Due to Chronic Nephritis	3 yrs.
Due to Generalized arteriosclerosis ?	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. C. Malin M.D. M. D. or other

Address Riverdale, Md. Date signed 3/13/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

03134

CERTIFICATE OF DEATH

Reg. Diat. No. 230

1. PLACE OF DEATH:
County: Pro. Geo. County
City or town: Berwyn Md. P
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(If newborn infants give residence of mother)
State: Maryland County: Pro Geo Co.
City or town: Berwyn Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4707 Guilford st.
(If rural, give LOCATION)
2.(a) If veteran, name war: No.

3. (a) FULL NAME: Maurice Edgar Price.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widower

6.(b) Name of husband or wife: Virginia Price
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Nov. 17. 1882.

8. AGE: Years	Months	Days	If less than one day
62			..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Telegraph Operator
11. Industry or business: Washington Terminal
FATHER — 12. Name: Wm. Thomas Price.
FATHER — 13. Birthplace: Maryland
MOTHER — 14. Maiden name: Algerine Turner
MOTHER — 15. Birthplace: Maryland
16. Informant: Raymond Lester Price
Address: 3324 - 2nd st. Washington D.C.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 8, 1945 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Colmar Manor Md
18. Funeral director: L. Gaschè sons
Address: Hyattsville Md.
19. March 8th 1945 (Date rec'd by registrar) John D. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 6, 1945, at 4:45 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 5 1945 to March 6 1945
and that I last saw h. alive on March 4, 1945
Immediate cause of death: Cancer of prostate gland — DURATION: about 2 years
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Ira Allen Griffith M. D. or other
Address: Berwyn Md. Date signed: 3/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

03135 Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Prince George
City or town Bradbury Park Md. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State MARYLAND County PRINCE GEORGE
City or town BRADBURY PARK (If outside city or town limits, write RURAL and give nearest town)
Street No. 4632 DAVIS AVE. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME John J. Rankin
3. (b) Social Security Number

4. Sex M
5. Color or race W
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Katherine L Rankin
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Sept 6, 1873
8. AGE: Years 71 Months Days If less than one day ..... hrs. ..... min.
9. Birthplace New York (Town, county, and state)
10. Usual occupation Retired
11. Industry or business
FATHER 12. Name John J. Rankin
13. Birthplace Germany
MOTHER 14. Maiden name Katherine Leck
15. Birthplace Ireland
16. Informant Katherine L Rankin
Address 613 - B St. N.E.
17. Burial Date thereof 3/31/45 (Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Cedar Hill
Location Suitland, Md.
18. Funeral director John Chambers Co
Address 517 11th St. S.E.
19. 3/28 1945 Amanda Dorsey Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1945, at 9:00 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1944, to March 27 1945, and that I last saw him alive on March 25 1945

	DURATION
Immediate cause of death myocardial failure	6 days
Due to Arteriosclerosis	10 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Harvey H. Ammerman, M.D. M. D. or other
Address 5440 Silver Hill Rd S.E. Date signed 3-27-45

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

CERTIFICATE OF DEATH

03136

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING (INK). Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, institution, or street address where death occurred: Leland Memorial Hospital

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: College Park (If outside city or town limits, write RURAL and give nearest town)

Street No.: Mowatt Lane (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: James Ross Reiley

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	W	m

6.(b) Name of husband or wife: Margaret Orrilla Reily

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): March 13, 1895

8. AGE: Years: 70 yrs | Months: | Days: 7 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Washington D.C. (Town, county, and state)

10. Usual occupation: Teacher

11. Industry or business:

FATHER — 12. Name: James Ross Reily

13. Birthplace: York, Pa

MOTHER — 14. Maiden name: Alice Pywell

15. Birthplace: Wash D.C.

16. Informant: Hospital Records

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 23 1945 (month) (day) (year)

Cemetery or crematory: Rock Creek

Location: Washington D.C.

19. Funeral director: J. Cheeks sons

Address: Hyattsville Md.

19. March 22 19 45 (Date rec'd by registrar) James Deuce Reg. R.S.S. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 20 19 45, at 6 05 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 14 19 45, to Mar 20 19 45 and that I last saw h[illegible] alive on Mar 20 19 45

Immediate cause of death	DURATION
Lobar pneumonia	12 days
Due to	
Due to	
Other conditions: Myocardial Failure	2 days
Hypertension	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: Same.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

23. SIGNATURE: L W. Malin M.D. M. D. or other

Address: Riverdale, Md Date signed: 3-21-45

3306

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (26)

CERTIFICATE OF DEATH

Reg. Dist. No. 231 — 03137

1. PLACE OF DEATH:
County: Prince George's Co.
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days
Hospital, institution, or street address where death occurred: Prince George's Gen. Hospital
How long in hospital or institution? 8 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pr. George's
City or town: Hyattsville.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5418 Gallatin St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ethel Reisinger

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widow

6.(b) Name of husband or wife: Frederick B. Reisinger
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 5, 1885

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
59	11	29		

9. Birthplace: Dist of Columbia (Town, county, and state)
10. Usual occupation: H. W.
11. Industry or business:
FATHER — 12. Name: Robert Heumann
13. Birthplace: N. J.
MOTHER — 14. Maiden name: Golden
15. Birthplace: Trenton, N. J.
16. Informant: John Reisinger
Address: 5418 Gallatin St.
17. Removal (Burial, cremation, or removal. Which?) Date thereof March 3rd 1945 (month) (day) (year)
Cemetery or crematory: (Burial to be in Rock Creek Cemet.)
Location: Washington, D.C.
18. Funeral director: Joseph B. Birch's Sons
Address: 3034-M St. N.W. - Wash., D.C.
19. March 3 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3 1945, at 7:40 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 23 1945 to March 3 1945
and that I last saw h.e.r. alive on March 2 1945

Immediate cause of death	DURATION
Auricular Fibrillation	2 days.
Mitral stenosis. Cor. B.P.	
Due to Chronic Myocarditis; duration.	Unknown.
cured.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Charles C. Hageage M.D. (M.D. or other)
Address: Mt. Rainier, Md. Date signed: March 3, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

03138

Reg. Diat. No. 233

1. PLACE OF DEATH:
County Prince George
City or town Westwood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 years
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Prince George
City or town Westwood
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Edward C Richards

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Ida Richards

7. Birth date of deceased (mo., day, yr.) Feb 12 1872 6.(c) If alive, give age 72 years

8. AGE: Years 72 Months Days 29 If less than one day hrs. min.

9. Birthplace Prince George (Town, county, and state)

10. Usual occupation Farming

11. Industry or business Farm

FATHER 12. Name John Richards

13. Birthplace Md

MOTHER 14. Maiden name Anna Gibbons

15. Birthplace Md

16. Informant Alvin Richards

Address Westwood, Md

17. burial (Burial, cremation, or removal. Which?) Date thereof Mar 9 1945 (month) (day) (year)

Cemetery or crematory Emanuel Church Cem

Location Westwood, Md

18. Funeral director Ritchie Bros

Address Upper Marlboro, Md

19. Mar 7 1945 (Date rec'd by registrar) Ernest N. Garner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6/45 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 3/6/45 to 3/6/45 and that I last saw h alive on 19

Immediate cause of death	DURATION
Cardiac Decompensation	
Due to Cardio-Vas-Renal Disease	
Due to Senility	4 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Geo. L. Wrenn M. D.

Address Waldorf Md M. D. or other Date signed 3/7/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 415

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-B)

CERTIFICATE OF DEATH

Reg. Diat. No. 03134 43

1. PLACE OF DEATH:
County Prince Georges
City or town Near Bowie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Near Bowie
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Thomas Clt. Richards

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October - 14 - 1898

8. AGE:

Years	Months	Days	If less than one day
46	4	20	hrs. min.

9. Birthplace Brandywine Md
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name Richard M. Richards
13. Birthplace Maryland
MOTHER 14. Maiden name Ella A. Cross
15. Birthplace Maryland
16. Informant Mrs Elizabeth A. Rawlings
Address Near Bowie
17. Burial Date thereof March 11th 45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Holy Trinity
Location Near Collington
18. Funeral director Martin Fiddemans Sons
Address Bowie Md
19 March 11 19 45 Mrs. J. W. Yingling Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1945 at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 14 1945 to Mar. 8 1945 and that I last saw h[illegible] alive on Mar. 6 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Unknown
Due to Par. attend.	" "
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. Beecroft M.D.
M. D. or other
Address Bowie Date signed 3/9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 178-A

03140

CERTIFICATE OF DEATH

Reg. Dist. No. 745

1. PLACE OF DEATH:
County Prince Georges
City or town Edmonston
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address (where death occurred): 4810-49th St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Edmonston
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4810-49th
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Kate Robertson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife William L. Robertson
8.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Feb 16, 1866

8. AGE:

Years	Months	Days	If less than one day
79			hrs. min.

9. Birthplace Michigan (Town, county, and state)
10. Usual occupation Home Wife
11. Industry or business Own Home

FATHER
12. Name Flavid Hoyt
13. Birthplace Ohio

MOTHER
14. Maiden name Wotton
15. Birthplace Ohio

16. Informant John B. Robertson
Address Washington D.C. 3101 Adams St. N.E.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 13, 1945 (month) (day) (year)
Cemetery or crematory Cedar Hill
Location Suitland Md

18. Funeral director F. Gaschè sons
Address Hyattsville Md.

19. March 13 1945 (Date rec'd by registrar) James Sevier By RDS Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Asphyxia	
Due to Acute Carbon Monoxide Poisoning	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 3-17-45
Where did injury occur? Edmonston (City or town) P.G. (County) Md (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury Escaping Gas Injured at work? no

23. SIGNATURE Deputy Medical Examiner M. D. or other
Address Hyattsville Md Date signed 3-17-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15-4

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (178-a)

CERTIFICATE OF DEATH

03141

Reg. Diat. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Prince Georges

City or town Edmonston

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Few months

Hospital, institution, or street address where death occurred: 4810 - 49th Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Edmonston

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4810 - 49th Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Elmer Robertson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Kate Robertson

6.(c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) July 26, 1862

8. AGE: Years 82 | Months 7 | Days 15 | If less than one day ... hrs. ... min.

9. Birthplace Washington DC (Town, county, and state)

10. Usual occupation Retired Fireman

11. Industry or business

FATHER 12. Name Thomas C. Robertson

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Sarah Elizabeth Lewis

MOTHER 15. Birthplace Washington DC

16. Informant Jessie E. Robertson

Address 3101 - Adams Street N.E. Washington, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 13, 1945 (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Suitland Md.

18. Funeral director F. Geeche sons

Address Hyattsville Md.

19. March 13, 1945 (Date rec'd by registrar) James Sevier Jay R.S.S. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11, 1945, at 7 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
asphyxia	
Due to Acute Carbon Monoxide Poisoning	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 3-11-45

Where did injury occur? Edmonston (City or town) PG. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Escaping gas Injured at work? No

Deputy Medical Examiner

23. SIGNATURE ... M. D. or other

Address Forestville Md. Date signed 3-12-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03142

CERTIFICATE OF DEATH

Reg. Diat. No. 243.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1325 - 13th St. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME WALTER E. ROSEBRO.

3.(b) Social Security Number –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mantie Rosebro
6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): August 13, 1862

8. AGE: Years	Months	Days	If less than one day
82	7	5	..... hrs. ..... min.

9. Birthplace: Bowling, Green, Kentucky (Town, county, and state)
10. Usual occupation: Retired (Gov't. Emp.)
11. Industry or business: –

FATHER
12. Name: Robert Rosebro
13. Birthplace: Kentucky

MOTHER
14. Maiden name: Mary Ragan
15. Birthplace: Indiana

16. Informant: Decedent
Address

17. Removal to (Burial, cremation, or removal. Which?) Date thereof: Mar 19, 1945 (month) (day) (year)
Cemetery or crematory:
Location: Washington, D.C.
18. Funeral director: Martin W. Hyson Co.
Address: 1300-N St. N.W. Wash. D.C.

19. Mar. 18 1945 (Date rec'd by registrar) Rowland S. Phillips Dep. Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 18th 1945, at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15th 1945, to March 18th 1945
and that I last saw him alive on March 18th 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	7 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Lee Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: 3/18/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

03143

CERTIFICATE OF DEATH

Reg. Diat. No. 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months - 6 days
Hospital, institution, or street address where death occurred: Glenn Dale Tuberculosis Sanatorium
How long in hospital or institution? same

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1316- Rhode Island Ave., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JAMES W. SAUNDERS

3.(b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

8.(b) Name of husband or wife: Martha Luppel, (deceased) (maiden)
8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 3-5-83

8. AGE: Years	Months	Days	If less than one day
62	0	9	hrs. min.

9. Birthplace: Loudon Co., Virginia (Town, county, and state)
10. Usual occupation: Owner & Mgr. restaurant
11. Industry or business: Restaurant
FATHER 12. Name: Christian Nicholas Saunders
FATHER 13. Birthplace: Loudon Co., Va.
MOTHER 14. Maiden name: Annie May Myers
MOTHER 15. Birthplace: Loudon Co., Va.
16. Informant: decedent
Address:
17. Removal (Burial, cremation, or removal. Which?) Date thereof: March 15, 1945 (month) (day) (year)
Cemetery or crematory: Removal to Washington D.C.
Location:
18. Funeral director: Martin W. Hysong
Address: 1300 N - St N.W. Washington D.C.
19. Mar. 14 1945 (Date rec'd by registrar) Rowland S. Phillips Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MARCH 14 1945, at 9:15 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 9 1945, to March 14 1945 and that I last saw h.. i.. m.. alive on March 14 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	7 mos.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Pincura M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: 3-14-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

03144

CERTIFICATE OF DEATH

Reg. Dist. No. 8 [illegible]

MARGIN RESERVED FOR BINDING

Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS A15

1. PLACE OF DEATH:

County: Prince Georges

City or town: Capt Pleasant

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 years

Hospital, institution, or street address where death occurred: 6306 - Forte Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Capt Pleasant

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6306 - Forte St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ada Dola Schultz

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married.

6.(b) Name of husband or wife: John William Schultz

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): June 23, 1876

8. AGE: Years	Months	Days	If less than one day
68			hrs. min.

9. Birthplace: Prince Georges County, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER

12. Name: Richard Curtin

13. Birthplace: Prince Georges County, Md.

MOTHER

14. Maiden name: Catherine Selby

15. Birthplace: Prince Georges County, Md.

16. Informant: John Wm. Schultz

Address: 6306 Forte St, Capt Pleasant, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Mar 21 (month) (day) 1945 (year)

Cemetery or crematory: Addison Chapel

Location: Seat Pleasant Md

18. Funeral director: F. Goodale Sons

Address: Hyattsville Md

19. Mar 19 1945 (Date rec'd by registrar) Jesse A. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 18 1945, at 11:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 15 1942, to Mar 2 1945 and that I last saw h.. alive on Mar 2 1945

	DURATION
Immediate cause of death: Coronary occlusion	30 min.
Due to: Coronary hypertension	10 years
Due to: Heart disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: William Brannin M. D.

Address: Capitol Heights, Md Date signed: 3/18/45

3/18/45

Coroner James D. Boyd called - permission given for signing certificate.

William Brauning MD

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

03145

CERTIFICATE OF DEATH

Reg. Dist. No. 237

1. PLACE OF DEATH:
County: Prince Georges
City or town: Brandywine P.O.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all her life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince Georges
City or town: Baden [illegible] Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Jane Scott

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	Widow

B.(b) Name of husband or wife: Richard Scott
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 4-1851

8. AGE: Years	Months	Days	If less than one day
94	0	17	..... hrs. ..... min.

9. Birthplace: Bald Eagle Prince Ge Co. Md
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business

FATHER
12. Name: Sylvester Smothers
13. Birthplace: Bald Eagle, Md

MOTHER
14. Maiden name: Lucy Young
15. Birthplace: Bald Eagle, Md

16. Informant: Laura Hutchins
Address: Brandywine, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 24/1945 (month) (day) (year)
Cemetery or crematory: St Peters Church Cem.
Location: Waldorf, Charles Co. Md.

18. Funeral director: Eugene C. Gumm
Address: Aquasco, Md.

19. March 23rd 1945 (Date rec'd by registrar) Mrs Henry B. Contee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 21 1945 at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3rd 1945, to March 21 1945
and that I last saw ... alive on March 16 1945

Immediate cause of death	DURATION
High Blood Pressure	Apparent
& Chronic Myocarditis	Indefinite
Due to: age	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John E. Bowers M.D.
M. D. or other
Address: Brandywine, Md. Date signed: 3/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

03146

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs., 3 mos., 4 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 3 yrs., 3 mos., 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2728 - Georgia Ave., N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: SIMMS, CLEVELAND

3.(b) Social Security Number: 578-16-6659

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	wid.

B.(b) Name of husband or wife: Laura W. Sims (dec.)

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 20, 1885

8. AGE: Years	Months	Days	If less than one day
59	6	11	hrs. min.

9. Birthplace: Fremont, North Carolina (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: Harry Sims

13. Birthplace: North Carolina

MOTHER — 14. Maiden name: Larry Hoaks

15. Birthplace: North Carolina

16. Informant: Decedent

Address

17. Removal to (Burial, cremation, or removal. Which?) Date thereof: Mar. 7, 1945 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

18. Funeral director: Henry S. Washington & Son

Address: 467 N St. N.W.

19. Mar. 2 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 2, 1945 at 9:30 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 15, 1944 to March 2, 1945

and that I last saw him alive on March 2, 1945

Immediate cause of death	DURATION
Tuberculosis pulmonary	39 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Lee Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: 3/2/45

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-2)

03147

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince George's

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 hours

Hospital, institution, or street address where death occurred: Leland Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Barbersville

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Grover Cleveland Slicht Jr.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Agnes N. Slicht

6.(c) If alive, give age: 19 years

7. Birth date of deceased (mo., day, yr.): May 2, 1923

8. AGE:	Years	Months	Days	If less than one day
	21	10	28	hrs. min.

9. Birthplace: Ohio (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: Grover Cleveland Slicht

FATHER — 13. Birthplace: Ohio

MOTHER — 14. Maiden name: Josephine Smithson

MOTHER — 15. Birthplace: Maryland

16. Informant: G. C. Slicht Sr.

Address: Laurel, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 2-45 (month) (day) (year)

Cemetery or crematory: Ivy Hill

Location: Laurel Md

18. Funeral director: The H. C. White Co. Inc

Address: Laurel Md

19. April 2 1945 (Date rec'd by registrar) Hans Berg Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30 1945, at 7:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Hemorrhage and shock	
Due to: Crushed chest and fractured skull	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 3/30/45

Where did injury occur? Laurel (City or town) P. G. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Route # 1

Means of injury: Pedestrian struck by car Injured at work? Yes

23. SIGNATURE: Deputy Medical Examiner James J. Bond M.D. or other

Address: Forestville Md Date signed 3-31-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1310)

CERTIFICATE OF DEATH

03148

Reg. Diat. No. 230

1. PLACE OF DEATH:

County: Prince Georges

City or town: Beltsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Beltsville (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: George Michael Smith

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): August 6, 1875

8. AGE: Years 64 | Months | Days 13 | If less than one day: hrs. min.

9. Birthplace: Beltsville Md (Town, county, and state)

10. Usual occupation: Grand M. S. Govt - Retired

11. Industry or business

FATHER — 12. Name: Michael Smith

13. Birthplace: England

MOTHER — 14. Maiden name: Fuden Elizabeth McLeod

15. Birthplace: Virginia

16. Informant: John D Smith

Address: Beltsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 22. 1945 (month) (day) (year)

Cemetery or crematory: St Johns

Location: Beltsville Md

18. Funeral director: F Gaschè sons

Address: Hyattsville Md

19. March 21st 1945 (Date rec'd by registrar) John D Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 19 1945, at 10 00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to: Cardiovascular Renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

Deputy medical Examiner

23. SIGNATURE: James S. Boyd M. D. or other

Address: Forestville Md Date signed: 3-19-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

03149

CERTIFICATE OF DEATH

Reg. Dist. No. 240

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Prince Georges County
City or town Brandywine
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 54 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Brandywine
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Rose Jeannette Smith

3. (b) Social Security Number

4. Sex: female
5. Color or race: white
6.(a) ~~Single, married~~, widowed, ~~or divorced~~

6.(b) Name of husband ~~or wife~~ Julius Kingsolving Smith
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 12. 1859

8. AGE: Years 77 | Months 1 | Days 8 | If less than one day ..5.. hrs. ..54.. min.

9. Birthplace Washington DC (Town, county, and state)

10. Usual occupation

11. Industry or business none

FATHER
12. Name Wm H. Squires
13. Birthplace Witham - Eng.

MOTHER
14. Maiden name Mary Rose Garner
15. Birthplace P.G. Co. Md

16. Informant David E. Lowerhead sr.
Address Brandywine. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3 11 '45 (month) (day) (year)
Cemetery or crematory Church of the Atonement
Location Chittenhamm
18. Funeral director Ritchie Bros
Address Upper Marlboro.

19. Mch 9 1945 (Date rec'd by registrar) F. H. Billingsley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 19 1945 at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1940 to 3 19 1945
and that I last saw h..... alive on ..... 19.....

Immediate cause of death Cardiac Decompensation — DURATION

Due to Cardio-Vas-Renal Disease — years

Due to Senility

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE E. D. Weber, M.D
M. D. or other
Address Waldorf Md Date signed 3/9/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1566

CERTIFICATE OF DEATH

03150

Reg. Dist. No. 245

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Pro Geo County
City or town: Brentwood Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: maryland County: Pro Geo Co
City or town: Brentwood Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4401 - 41 street
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Thomas Belt Smoot

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: — years
7. Birth date of deceased (mo., day, yr.): Feb 8 1871

8. AGE: Years	Months	Days	If less than one day
74			hrs. min.

9. Birthplace: Md (Town, county, and state)
10. Usual occupation: Merchant
11. Industry or business: sandwitch shop
FATHER — 12. Name: Thomas W Smoot
FATHER — 13. Birthplace: Md.
MOTHER — 14. Maiden name: Annie E. Cox
MOTHER — 15. Birthplace: Md
16. Informant: Mrs Georgia L. Lee.
Address: Brentwood Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 17, 1945 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: suitland Md
18. Funeral director: F Gasch's sons
Address: Hyattsville Md.
19. March 17 1945 (Date rec'd by registrar) Jas Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 15 1945, at 10 16 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1944 to March 15 1945
and that I last saw h alive on March 15 1945

Immediate cause of death	DURATION
Myocardial degen	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Hyattsville Md Date signed: March 16/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-C)

03151

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 mos., 26 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 9 mos., 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4109- 34th St. Mt. Ranier
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME: Cornelius D. Soper

3.(b) Social Security Number: 578-10-6202

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lillian Soper
6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): August 27, 1880

8. AGE: Years	Months	Days	If less than one day
64	6	15	...hrs. ...min.

9. Birthplace: Frederick, Maryland
(Town, county, and state)

10. Usual occupation: Trainman

11. Industry or business:

FATHER
12. Name: Perry Soper
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary E. Baker
15. Birthplace: Maryland

16. Informant: Decedent
Address:

17. (Burial, cremation, or removal. Which?) Removal — Date thereof (month) (day) (year) March 15 '45
Cemetery or crematory: To Mt. Rainer, Md.
Location:

18. Funeral director: William J. Nalley
Address: 3200-R.I. Ave. Mt. Rainier, Md.

19. (Date rec'd by registrar) Mar. 14 1945 Rowland S. Phillips Deputy Registrar (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 14 1945 at 6-40' P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 17 1944, to Mar. 14 1945
and that I last saw him alive on Mar. 14 1945

Immediate cause of death	DURATION
Tuberculosis of Lungs	2 yr. 9 mo
Tuberculous Laryngitis	1 yr.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: ... Injured at work?

23. SIGNATURE: Daniel Leo Pincare M.D. (M. D. or other)
Address: Glenn Dale, Md. Date signed: 3-14-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

03152

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince Georges
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 days
Hospital, institution, or street address where death occurred:
Leland Memorial Hosp.
How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: University Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6403 Queens Chapel Rd
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Milda Lone Stauber

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
fe	W	married

6.(b) Name of husband or wife: Charles John Stauber
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): June 8, 1897

8. AGE:

Years	Months	Days	If less than one day
47	9	12	____ hrs. ____ min.

9. Birthplace: Wisconsin (Town, county, and state)
10. Usual occupation: Clerical
11. Industry or business
FATHER 12. Name: Charles B Van Gorden
13. Birthplace: Illinois
MOTHER 14. Maiden name: Lora Olive Northrop
15. Birthplace: Wisconsin
16. Informant: Hospital Records
Address
17. Burial, cremation, or removal. Which? Transportation. Date thereof March 24, 1945 (month) (day) (year)
Cemetery or crematory: Merrilan
Location: Merrilan Wisconsin
18. Funeral director: F Gascho Sons
Address: Hyattsville Md.
19. March 22 1945 (Date rec'd by registrar) James Devere Reg. R.S.S. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 20 1945, at 9 20 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1945; to Mar 20 1945
and that I last saw h... alive on Mar 20 1945

Immediate cause of death	DURATION
Cerebral hemorrhage and	3 weeks
right hemiplegia	
Due to: Hypertension	5 Years
Due to: Pyelonephritis	20 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results: atrophied kidneys enlarged heart
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) ____ (County) ____ (State)
Injured at home, farm, industry, public place (where?): ____
Means of injury: ____ Injured at work?

23. SIGNATURE: L. O. Malin M D
M. D. or other
Address: Lanham, Md. Date signed 3-21-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03153

CERTIFICATE OF DEATH

Reg. Diat. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Georges
City or town: Cheverly Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 days
Hospital, institution, or street address where death occurred: Prince Georges Gen. Hospital Cheverly
How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pr. Georges
City or town: College Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7212 Bowdin ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME
Helen M. Suit

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 7 - 1944

8. AGE: Years | Months: 8 | Days: 24 | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Child
11. Industry or business
FATHER 12. Name: Eugene Suit
FATHER 13. Birthplace: Md
MOTHER 14. Maiden name: Rose Talbert
MOTHER 15. Birthplace: Maryland
16. Informant: mother
Address: 7212 Bowdin ave College Park
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-3-45 (mouth) (day) (year)
Cemetery or crematory: Mt. Olivet Cemty
Location: Wash. D.C.
18. Funeral director: W.W. Chambers Co
Address: Riverdale Md
19. 3/3 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-2 1945, at 3 40 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 7 - 1945, to March 2 1945
and that I last saw h.er alive on March 1st 1945

	DURATION
Immediate cause of death: Influenzal Meningitis	21 days
Due to: Hemophilus Influenza	21 days.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Cultures
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: I.S.I.O.R. M. LAVINE, M. D. or other
Address: Mt. Rainier, Md. Date signed: 3.2.45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3-a)

03154

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince Georges

City or town: Chapel Oaks (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Month

Hospital, Institution, or street address where death occurred: 120 - 57th Ave N.E.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Chapel Oaks (If outside city or town limits, write RURAL and give nearest town)

Street No. 120 - 57th Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Roscoe Talbert

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Lottie Talbert

6.(c) If alive, give age: 21 years

7. Birth date of deceased (mo., day, yr.): Dec 7, 1918

8. AGE: Years: 26 | Months: 3 | Days: 19 | If less than one day: hrs. min.

9. Birthplace: Greenwood S.C. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: U. S. Govt.

FATHER — 12. Name: James Talbert — 13. Birthplace: S. C.

MOTHER — 14. Maiden name: Julia Carroll — 15. Birthplace: S. C.

16. Informant: Elma Talbert — Address: Chapel Oaks, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof March 27, 1945 (month) (day) (year)

Cemetery or crematory: Washington, D.C.

Location:

18. Funeral director: J. T. Lewis & Sons

Address: 30 & Ost. N.E.

19. March 27 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 26 1945, at 11:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Subarachnoid Hemorrhage	
Due to: Aneurysm of Circle of Willis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Deputy Medical Examiner M. D. or other

Address: Forestville Md. Date signed 3-26-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

03155

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Transient

Hospital, Institution, or street address where death occurred: White Flowers Shop

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State: District of Columbia County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1401 - Emerson

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Walter J. Joslett

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1881

8. AGE:

Years	Months	Days	If less than one day
63			hrs. min.

9. Birthplace: England (Town, county, and state)

10. Usual occupation: Superintendent

11. Industry or business: Funeral Parlors

FATHER

12. Name: Walter Joslett

13. Birthplace: England

MOTHER

14. Maiden name: unknown

15. Birthplace: unknown

16. Informant: Edward J. O'Connor

Address: 714 - 18th St. N.W. Washington D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: March 12, 1945 (month) (day) (year)

Cemetery or crematory: Hyson Funeral Home

Location: 13th & D St. N.W. Washington D.C.

18. Funeral director: L. Gaetia & Sons

Address: Hyattsville Md.

19. March 12 1945 (Date rec'd by registrar) James Lewis By R.S.S. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 11 1945, at 3:0 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Deputy medical examiner James J. Long M. D. or other

Address: Hyattsville Md. Date signed: 3-12-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (37)

03156

CERTIFICATE OF DEATH

Reg. Dist. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince George's

City or town: (Rural) Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs., 10 mos., 13 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 6 yrs., 10 mos., 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 440 Newton Place N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war: –

3.(a) FULL NAME: THOMAS JEFFERSON TATE

3.(b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Nellie May Tate

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): February 23, 1887

8. AGE:

Years	Months	Days	If less than one day
58	–	17	... hrs. ... min.

9. Birthplace: Trevilians, Virginia (Town, county, and state)

10. Usual occupation: Pharmacist

11. Industry or business: –

FATHER

12. Name: Philip Tate

13. Birthplace: Frederic Hall, Virginia

MOTHER

14. Maiden name: Ella M. Turner

15. Birthplace: Trevilians, Virginia

16. Informant: Decedent

Address

17. Removal to (Burial, cremation, or removal. Which?) Date thereof: Mar 10, 1945 (month) (day) (year)

Cemetery or crematory

Location: Washington, D.C.

18. Funeral director: J. Wm. Lee Sons

Address: 300-4th St NE

19. Mar 10 1945 (Date rec'd by registrar) Rowland S. Phillips Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 10, 1945, at 11:A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 27, 1938, to Mar 10 1945

and that I last saw him alive on Mar. 10 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	7 yrs 7 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.

M. D. or other

Address: Glenn Dale, Md. Date signed: 3/10/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-0)

CERTIFICATE OF DEATH

03157

Reg. Dist. No. 231

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Prince Georges
City or town: Chevrely, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 hours
Hospital, Institution, or street address where death occurred: 9 hours
How long in hospital or institution? 9 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Landover
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Taylor, Mrs. Frances

3.(b) Social Security Number

4. Sex	Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Widowed

6.(b) Name of husband or wife: Joseph R Taylor.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 8, 1876

8. AGE: Years	Months	Days	If less than one day
68	6	5	..... hrs. ..... min.

9. Birthplace: Wash. D.C.
(Town, county, and state)
10. Usual occupation: H. W.
11. Industry or business
FATHER 12. Name: Boyland
13. Birthplace: Washington D.C
MOTHER 14. Maiden name: Unknown
15. Birthplace: "
16. Informant: John C Taylor (son.)
Address: 1322 45th St. N.E.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 15, 1945. (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Colmar Manor Md
18. Funeral director: L Gaschis sons
Address: Hyattsville Md
19. 3/15 1945 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 13 1945, at 5:50 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12 1945, to March 13 1945 and that I last saw h.e.r. alive on March 13 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	10 hours
Due to: Hypertension	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Charles C. Hageage M. D.
M. D. or other
Address: Mt. Rainier, Md. Date signed: March 14, 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (180)

Counted 03458 a. d

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince Georges

City or town Meadows

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Rosaryville Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Meadows

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rosaryville Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Charles E. Thomas

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 70 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name William H. Thomas

13. Birthplace Maryland

MOTHER 14. Maiden name Amanda Fry

15. Birthplace Maryland

16. Informant Henry Thomas

Address Rockville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-15-45 (month) (day) (year)

Cemetery or crematory Evergreen

Location Baltimore, Md

18. Funeral director T. Gaschis Son

Address Hyattsville, Md.

19. 3/14 19 45 Thos. D. Griffith Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 19 45, at 1:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ..., to ... 19 ...

and that I last saw h... alive on ... 19 ...

	DURATION
Immediate cause of death Shock	
Due to Unusual [redacted]	
Due to 3rd degree burns	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 3-13-45

Where did injury occur? Meadows (City or town) P.G. (County) Md (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Horse turned over Injured at work? No

23. SIGNATURE Deputy Medical Examiner M.D. or other

Address Forestville Md Date signed 3-14-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

03159

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: PRINCE GEORGE

City or town: MT RAINIER

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 YEARS

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MARYLAND County: PRINCE GEORGE

City or town: MT. RAINIER

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4110 - 29TH. STREET

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: OLGA K. THOMPSON

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6.(b) Name of husband or wife: HARRY THOMPSON

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): DEC. 2 1879

8. AGE: Years: 65 | Months: 3 | Days: 26 | If less than one day: ..... hrs. ..... min.

9. Birthplace: SWEDEN (Town, county, and state)

10. Usual occupation: HOUSEWIFE

11. Industry or business

FATHER

12. Name: (UNKNOWN) ADOLPHSON

13. Birthplace: SWEDEN

MOTHER

14. Maiden name: HILDA (UNKNOWN)

15. Birthplace: SWEDEN

16. Informant: MRS. EDNA T. SANDBERG

Address: 4110 - 29TH. ST. MT. RAINIER, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-31-45 (month) (day) (year)

Cemetery or crematory: ARLINGTON NAT'L. CEMETERY

Location: ARLINGTON VA.

18. Funeral director: Francis J. Bolling

Address: 3821-14TH. ST. N.W. WASH. D.C.

19. March 29 1945 (Date rec'd by registrar) James Sweeney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 28 1945 at 1 15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 14 1945 to Mch 28 1945 and that I last saw h.. alive on Mch 28 1945

Immediate cause of death	DURATION
Cardio-Renal	
Vascular	
Due to Chronic myocardosis	6 mos.
Due to Chronic Nephritis	10 yrs.
Other conditions Diabetes	5 yr.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Wm H. Norton M. D. or other

Address: 3827-34ST MT RAINIER MD. Date signed 3-28-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

03160

Reg. Diat. No. 242

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Prince Georges

City or town: Fairmont Heights

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred: 1004 - 58th Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Fairmont Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1004 - 58th Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Leonard Mitchell Tibbs

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Mary Tibbs

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 8, 1894

8. AGE: Years: 50 | Months: 8 | Days: 23 | If less than one day: hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: William Tibbs

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: [illegible]

MOTHER — 15. Birthplace: [illegible]

16. Informant: Blanche J. Brush

Address: 1004 - 58th Ave., Fairmont Heights

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 4 1945 (month) (day) (year)

Cemetery or crematory: Langnes -

Location: Washington

18. Funeral director: J. B. Johnson

Address: Washington D.C.

19 Apr. 9 (Date rec'd by registrar) 1945 Irene A. Bohmer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 31 19 45, at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: [redacted] Date of [redacted]

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: James T. Boyd M. D. or other

Address: Forestville Md. Date signed 3-31-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

03161

Reg. Diat. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred: 3 days
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Wisconsin County:
City or town: Milwaukee, Wisc.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 310 East Archer Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Tishler, M. James

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Mrs. Julia Tishler
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE:

Years	Months	Days	If less than one day
77	6	14	..... hrs. ..... min.

9. Birthplace: Wisconsin (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business:

FATHER
12. Name: Tishler, John
13. Birthplace: Bohemia

MOTHER
14. Maiden name: Barney, Kathryn
15. Birthplace: Bohemia

16. Informant: Mrs. Julia Tishler
Address: Milwaukee

17. Transportation (Burial, cremation, or removal. Which?) Date thereof Mar 23, 1945 (month) (day) (year)
Cemetery or crematory:
Location: Milwaukee, Wisconsin
18. Funeral director: F. Gaschi Sons
Address: Hyattsville, Md.

19. 3/23 1945 Amanda Dauney
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-21 1945, at 11:40 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 3-18 1945, to 3-21 1945 and that I last saw h.i.m alive on 3-20 1945

Immediate cause of death	DURATION
Acute Fibrinal Peritonitis	1 week.
Due to Multiple Diverticuli with rupture	7
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: Dr. ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: John J. Maloney, M.D.
M. D. or other
Address: Cheverly, Md. Date signed 3-22-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

03162

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Prince George
City or town Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs
Hospital, institution, or street address where death occurred: Sacred Heart Home
How long in hospital or institution? 3 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County St Marys
City or town Leonardstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William H Turner

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 12 - 1875

8. AGE: Years 69 | Months 5 | Days 18 | If less than one day ..... hrs. ..... min.

9. Birthplace Leonardstown Md
(Town, county, and state)

10. Usual occupation Farmer retired

11. Industry or business

FATHER
12. Name Stanton Turner
13. Birthplace Md.

MOTHER
14. Maiden name Rosabelle Wood
15. Birthplace Md.

16. Informant Sacred Heart Home
Address Hyattsville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 31 - 1945 (month) (day) (year)
Cemetery or crematory
Location Washington D.C.

18. Funeral director Albert J Eaker
Address 641 - H. St. N.E. Washington D.C.

19. March 31 1945 (Date rec'd by registrar) James Lucas By R.S.S. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1945, at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1945, to Mar 30 1945
and that I last saw h[illegible] alive on Mar 29 1945

Immediate cause of death	DURATION
Apoplexy	5 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Thomas Hallinan MD
M.D. or other
Address 323 - H St NE Date signed 3-30-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-6)

03163

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1704 V. St. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME: Otis VAILES

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: –
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 25, 1914

8. AGE: Years	Months	Days	If less than one day
30	8	21	hrs. min.

9. Birthplace: Wilson, North Carolina (Town, county, and state)
10. Usual occupation: Bus Boy
11. Industry or business: –

FATHER
12. Name: Luther Vailes
13. Birthplace: Wilson, North Carolina

MOTHER
14. Maiden name: Della Williamson
15. Birthplace: Elm City, North Carolina

16. Informant: Decedent
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof 3 · 23 · 45 (month) (day) (year)
~~Cemetery or crematory~~ Removal to Wash. D.C.
Location:

18. Funeral director: Malvaw T Sekey
Address: 424 - R St. N.W.

19. Mar. 17 1945 (Date rec'd by registrar) Rowland S. Phillips Dep. Coord. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 17 1945, at 5-30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/24 1945, to 3/17 1945
and that I last saw h. / N. alive on 3/17 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	15 M.O.
Due to:	
Due to:	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: 3/17/45

M

I

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B-6

03164

CERTIFICATE OF DEATH

Reg. Diat. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Chbourg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 47 days.
Hospital, institution, or street address where death occurred:
Prince George General Hospital
How long in hospital or institution? 47 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County: Pr. Geo.
City or town: Bowie
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Md.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Vermillion, Mrs Spencer Elmer. Vermillion

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Vermillion Mrs Ena
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 12, 1896

8. AGE: Years	Months	Days	If less than one day
49	1	9	hrs. min.

9. Birthplace: Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Vermillion, John
13. Birthplace: Pa

MOTHER
14. Maiden name: Schneideman, Emma
15. Birthplace: Pa

16. Informant: Mrs Ena Vermillion
Address: Bowie, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 25, 1945 (month) (day) (year)
Cemetery or crematory: St Barnabas
Location: Leeland Md

18. Funeral director: F Gaston Long
Address: Hyattsville Md

19. 3/24/45 (Date rec'd by registrar) Amanda Demuth Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-21-45 19 at 12:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 1945, to March 21 1945
and that I last saw him alive on March 21 1945

Immediate cause of death	DURATION
Pulmonary Miliary conglomerate Tuberculosis with Valvular heart condition	about 1 months
Due to	
Due to	
Other conditions: Bronchio Pneumonia and tumors	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: Post Mortem confirms Tuberculosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Louis H. Jirud M.D.
M. D. or other
Address: Cottage City, Md. Date signed 3-22-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Pulm. Mil. Cons, TBc c̄ ulceration & cavitation

See ? TBc

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

03165 45

Reg. Diat. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 hr

Hospital, institution, or street address where death occurred: Leland Memorial Hospital

How long in hospital or institution? 1 hr

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Berwyn Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Fontaine Ln.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Clinton McWilliams Walker

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Married

6.(b) Name of husband or wife: Mary E. Walker

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 22, 1886

8. AGE: Years: 58yrs | Months: 8 | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Washington D.C. (Town, county, and state)

10. Usual occupation: Chauffeur

11. Industry or business:

FATHER — 12. Name: George Noble Walker

13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown

15. Birthplace: ----------

16. Informant: C. M. Walker Jr.

Address: Berwyn, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 28, 1945 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Lanham Md.

18. Funeral director: F. Gaschen Sons

Address: Hyattsville Md

19. March 28 1945 (Date rec'd by registrar) Jas Devey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/25/45 19..... at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/23 19 45, to ..... 19.....

and that I last saw h. liv. alive on 3/23/45 19.....

Immediate cause of death	DURATION
Resp. failure	
Due to: Cardiac failure	
Due to: Coronary Thrombosis.	
Other conditions: Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: William L. Eisen M. D. or other

Address: 30 B. Ridge Rd Greenbelt Md. Date signed: 3/26/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03166

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 mos., 7 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 11 mos., 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 412 K. St. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME: WALKER, WILLIAM

3.(b) Social Security Number: 719-09-3413

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	Married

6.(b) Name of husband or wife: Esther Walker
6.(c) If alive, give age: 31 years
7. Birth date of deceased (mo., day, yr.): July 4, 1912

8. AGE: Years	Months	Days	If less than one day
32	8	16	..... hrs. ..... min.

9. Birthplace: Columbia, South Carolina (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: –

FATHER
12. Name: Jim Walker
13. Birthplace: Columbus, Georgia

MOTHER
14. Maiden name: Lizzie Walker
15. Birthplace: Columbia, South Carolina

16. Informant: Decedent
Address

17. Removal to (Burial, cremation, or removal. Which?) Date thereof: Mar. 21, 1945 (month) (day) (year)
Cemetery or crematory
Location: Washington, D.C.
18. Funeral director: Malvan & Dickey Inc.
Address: 427 M St NW

19. Mar 20, 1945 (Date rec'd by registrar) Rowland S. Phillips Dep. Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 20, 1945, at 7 p.m.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 4/6 1944, to 3/20 1945
and that I last saw h... alive on 3/20 1945

Immediate cause of death	DURATION
Tuberculosis pulmonary	12 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Lee Pincura M.D. M. D. or other
Address: Glenn Dale, Md. Date signed 3/20/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15, Md.

03167

CERTIFICATE OF DEATH

Reg. Diat. No. 245

1. PLACE OF DEATH:

County Prince George

City or town Riverdale - Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 Mocs

Hospital, institution, or street address where death occurred:
Eugene Leland Memorial Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Prince Geurge

City or town Riverdale Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4701 Ravenswood Road Apt 17
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

White, Elmer - Golen

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 25 - 1943

8. AGE: Years	Months	Days	If less than one day
1	20 8	15	..... hrs. ..... min.

9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name White, Elmer - Bernard

13. Birthplace Fredericksburg, Va.

MOTHER 14. Maiden name McCarty, Helen Irene

15. Birthplace Confluence Pa.

16. Informant Elmer B. White

Address 4701 Ravenswood Rd. Riverdale md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-13-45 (month) (day) (year)

Cemetery or crematory Ft. Lincoln Cemetery

Location Wash. D.C.

18. Funeral director M.W. Chambers Co

Address Riverdale md.

19. March 12 1945 James Lucas By R.S.S. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1945 at 6:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-8-45 1945, to ..... 19....

and that I last saw h..... alive on ..... 19....

Immediate cause of death	DURATION
Congenital Heart Disease	20 mo.
Stenosis of pulmonary valve	
Due to	
Due to	
Other conditions Acute Upper Resp. Infection	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results See Diag

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE L. W. Malin M.D.
M. D. or other

Address Riverdale, Md Date signed 3-11-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

03168

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yrs., 3 mos., 25 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 yr., 3 mos., 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 648 G. St. N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: THOMAS WILLIAM WHITLOW

3.(b) Social Security Number: 579-09-3943

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Alice Whitlow

6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): April 24, 1897

8. AGE: Years	Months	Days	If less than one day
47	10	9	..... hrs. ..... min.

9. Birthplace: Fork Union, Virginia
(Town, county, and state)

10. Usual occupation: Wood Jointer

11. Industry or business:

FATHER
12. Name: Thomas W. Whitlow
13. Birthplace: Fork Union, Virginia

MOTHER
14. Maiden name: Sleans Jackson
15. Birthplace: Fork Union, Virginia

16. Informant: Decedent
Address:

17. Removal to
(Burial, cremation, or removal. Which?)
Date thereof: Mar. 5, 1945
(month) (day) (year)

Cemetery or crematory:
Location: Washington, D.C.

18. Funeral director: J. Wm. Leese Sons Co
Address: 300 - 4th. N.E.

19. Mar. 4, 1945 Rowlands Phillips
(Date rec'd by registrar) Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MARCH 4 1945 at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 - 8 — 1943, to 3 - 4 1945 and that I last saw h.. i.m alive on March 4 1945

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 1 year 6 mos.

Due to:

Due to:

Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 3/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-2)

03169

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mos., 25 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 6 mos., 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give resideoce of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1442 S. St. N. W.
(If rnral, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: MATTHEW WILSON.

3.(b) Social Security Number: 239-07-4750

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Lilly Mae Wilson

6.(c) If alive, give age: 28 years

7. Birth date of deceased (mo., day, yr.): April 15, 1917

8. AGE:

Years	Months	Days	If less than one day
27	10	22	hrs. min.

9. Birthplace: Newburg, South Carolina
(Towo, conoty, and etate)

10. Usual occupation: Factory laborer

11. Industry or business:

FATHER
12. Name: Antine Wilson
13. Birthplace: Newburg, South Carolina

MOTHER
14. Maiden name: Lula Douglas
15. Birthplace: Newburg, South Carolina

16. Intormant: Decedent
Address:

17. Removal to (Burial, crematioo, or removal. Which?) Date thereof: Mar. 9 1945 (mooth) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

19. Funeral director: St. Joseph's Funeral Home

Address: 306 L Street, N. W.

19. Mar 8 1945 (Date rec'd by registrar) Rowland S. Philips Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 8th 1945 at 11 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 2nd 1944 to March 8th 1945 and that I last saw him alive on March 8th 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	11 Mos.
Due to	
Due to	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please nnderline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (Conoty) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Pincura M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 3/8/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-F)

03170

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 1 mo., 24 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 yr. 1 mo., 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County: Washington

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No. 636 Hamilton St. N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: –

3. (a) FULL NAME: WRIGHT RUDOLPH

3. (b) Social Security Number: 577-07-8057

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lillian E. Wright

6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): July 18, 1904

8. AGE:

Years	Months	Days	If less than one day
40	8	4	...hrs. ...min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Plumber

11. Industry or business:

FATHER
12. Name: Edmond Wright
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Margaret Phillips
15. Birthplace: Washington, D. C.

16. Informant: Decedent
Address:

17. (Burial, cremation, or removal. Which?) Removal — Date thereof: 3 – 22 – 45 (month) (day) (year)

Cemetery or crematory: to Wash.

Location:

18. Funeral director: Deal Funeral Home

Address: 4812 Georgia Ave. N.W.

19. Mar. 22, 1945 (Date rec'd by registrar) Rowland L. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 22, 1945, at 8:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/26 1944, to 3/22 1945

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Tuberculosis pulmonary	39 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 3/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (88-a)

0317

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince George
City or town: Near Dist Hgts
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Geo.
City or town: Near Dist. Hgts.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6800 Marlboro Pike.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: WILLIAM HOWARD WYMAN

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Lula

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 12th 1868

8. AGE: Years: 77 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: —

FATHER
12. Name: John F. Wyman
13. Birthplace: N.J.

MOTHER
14. Maiden name: Hester Morehead
15. Birthplace: Va

16. Informant: Mrs Blanche C. Porter
Address: 6800 Marlboro Pike

17. Removal (Burial, cremation, or removal. Which?) Date thereof 3-14-45 (month) (day) (year)

Cemetery or crematory
Location: Washington D.C.

18. Funeral director: W. W. Chambers Co.
Address: 517 11th St S.E.

19. 3-14 19 45 (Date rec'd by registrar) Thos. D. Griffith (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 14 19 45, at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3 19 45, to March 14 19 45, and that I last saw him alive on March 14 19 45

	DURATION
Immediate cause of death: Cerebral Hemorrhage	9 days
Due to: General Arteriosclerosis	Unknown
Due to: —	
Other conditions: Paralysis lower half of body	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Washington 19 DC Date signed 3/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15